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No. ———

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

ANNELIESE B. LAMB, individually and on behalf of all other persons similarly situated,
Petitioner,

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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QUESTIONS PRESENTED

1. Whether a private group disability insurance policy which, after a worker's permanent disability, reduces insurance payments from the insurer by the amount of increases in social security disability benefits effects an "assignment" or "transfer" of those benefit increases in violation of Section 207 of the Social Security Act, 42 U.S.C. § 407.

2. Whether a private group disability insurance policy which, after a worker's permanent disability, reduces insurance payments by the amount of dependent children's social security benefits received by the worker as representative of his or her dependent children deprives those children of benefits guaranteed to them under Section 202 (d)1 of the Social Security Act, 42 U.S.C. § 402(d)1, and implementing regulations, 20 C.F.R. § 404.1601 *et seq.*

PARTIES TO THE PROCEEDINGS

Plaintiff-Appellant-Petitioner is Anneliese B. Lamb.

Defendant-Appellee-Respondent is Connecticut General Life Insurance Company.

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

OPINIONS BELOW

The opinion of the Third Circuit is reported at 643 F.2d 108 (3d Cir. 1981) (advanced sheet) and is reproduced at App. 1a. The opinion of the District Court granting summary judgment on the amended complaint is not officially reported; the opinion and final judgment are reproduced at App. 11a and 50a, respectively. No written opinion was filed by the District Court in granting defendant's motion for summary judgment on the original complaint. The Court's oral ruling and order granting summary judgment with leave to file an amended complaint are reproduced at App. 51a and 53a, respectively.

STATEMENT OF JURISDICTION

The judgment of the United States Court of Appeals for the Third Circuit was entered on February 23, 1981. Within 90 days of that date, on May 22, 1981, Circuit Justice Brennan extended to June 23, 1981 the time in

which to file this petition for a writ of certiorari. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

This case involves the following statutes and regulations:

42 U.S.C. § 402(d)1

42 U.S.C. § 407

20 C.F.R. §§ 404.1601, 1603, 1605, 1607

These provisions are set forth at App. 111a.

STATEMENT OF THE CASE

A. Introduction

This Petition seeks review of a judgment of the Third Circuit Court of Appeals allowing private disability insurers to deduct Social Security disability benefits from insurance proceeds otherwise payable to disabled workers under contributory long-term disability insurance policies. The practical effects of these deductions is to deprive disabled policy beneficiaries of cost-of-living increases in primary disability benefits that would otherwise come to them under Section 207 of the Social Security Act ("SSA"), 42 U.S.C. § 407,[1] and to deprive their dependent children of benefits provided for their use under

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[1] 42 U.S.C. § 407 provides as follows:

> The right of any person to any *future* payment under this subchapter shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this subchapter shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law. (Emphasis added.)

Section 202(d)1 of the statute, 42 U.S.C. § 402(d)1,[2] and implementing regulations.

B. Proceedings Below

On June 29, 1977, petitioner Lamb instituted suit in the United States District Court for the District of New Jersey seeking damages and injunctive relief against respondent Connecticut General Life Insurance Company. Petitioner, a permanently disabled worker, brought suit for herself and as a test case for other disabled workers. Her complaint and amended complaint alleged that respondent's practice of deducting federal benefits from insurance proceeds it was required to pay violated both state and federal law, including Sections 207 and 202 (d)1 of SSA. Respondent admitted the practice, but denied liability.[3]

Prior to the completion of discovery, respondent moved for summary judgment on the federal counts of the complaint. That motion was granted on July 31, 1978, with leave given to file an amended complaint. After the filing of the amendment, but still prior to the completion of discovery, respondent moved for summary judgment on the amended federal counts. On March 3, 1980, the District Court granted respondent's motion for summary judgment on the federal claims and dismissed the pendent state law claims for lack of subject matter jurisdiction. The United States Court of Appeals for the Third Circuit affirmed in a decision issued February 23, 1981.

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[2] 42 U.S.C. § 402(d)1 states in relevant part:

> Every child . . . of an individual entitled to . . . disability insurance benefits . . . shall be entitled to a child's insurance benefit.

[3] The complaint also asserted three additional state law counts under pendent jurisdiction relating to misrepresentation in the sale of respondent's policies and other misconduct actionable under state law.

C. Statement of Facts

Prior to becoming permanently disabled in 1970, petitioner was employed as a hospital dietician.[4] In October, 1969, her employer purchased a long-term employee disability policy from respondent. The policy became effective upon the enrollment of a specified number of petitioner's co-workers.[5] The plan was voluntary and contributory, with employees paying 75 per cent of the premiums by payroll deduction.[6] The premiums were calculated on the basis of the full amount of an employee's anticipated monthly income benefit. The insurer did *not* consider amounts that would be received from collateral sources such as Social Security or workmen's compensation in calculating the premiums.[7]

The plan provided that, upon disability, the employee would receive income benefits of 70 per cent of monthly earnings, to a maximum of $1,500. The plan also provided that monthly benefits would be reduced by "Other Income Benefits," including:

> (1) any periodic cash payment provided on account of the Employee's disability . . . (b) by the Federal Social Security Act, including benefits payable to the Employee's dependents on account of the Employee's disability . . .; and
>
> (2) any Federal Old Age Benefits provided under the Federal Social Security Act. (App. at 92a.)

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[4] App. at 12a; Lamb Deposition (December 12, 1978) at 6.

[5] App. at 2a, 12a; Jenson Affidavit (March 2, 1978) at 2.

[6] App. at 68a; Respondent's Answer to Verified Class Action Complaint (September 2, 1977), at ¶ 8; Spina Deposition (January 3, 1979) at 29.

[7] App. at 64a. The facts developed in the trial court did not disclose the precise method by which the premiums were calculated by respondent since, as reflected in respondent's interrogatory answers, relevant documentation maintained by respondent had been destroyed. App. at 72a.

Petitioner became eligible for insurance benefits because of disability in January, 1971. App. at 3a. In addition, petitioner qualified for primary disability and dependent children's benefits under the Social Security program. App. at 3a. In 1971, petitioner's monthly Social Security benefits initially were $199.30 ($130.80 in primary disability benefits and $68.50 in dependent children's benefits).[8] Since then, these federal benefits have been periodically increased under legislation designed to adjust Social Security benefits to the rising cost of living.[9] By June 1980, petitioner's total Social Security benefits had risen to $476.00.

None of these benefits, however, has gone towards fulfilling the purpose intended by Congress. Instead, respondent has received the economic benefit of all increases in petitioner's primary disability benefits as well as all benefits received by her on account or her dependent children. Because respondent has deducted these payments from petitioner's insurance proceeds, petitioner's total monthly income from these sources has remained constant since 1971, while the benefits paid to her directly by respondent have continuously declined.[10]

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[8] Respondent's Answer to First Amended Complaint (September 29, 1978), at ¶ 19.

[9] *E.g.*, Act of December 31, 1973, Pub. L. No. 93-233, 87 Stat. 948; Act of July 9, 1973, Pub. L. No. 93-66, 87 Stat. 153; Act of July 1, 1972, Pub. L. No. 92-336, 86 Stat. 406.

[10] Petitioner's Social Security Act claims only contest the offset of *post*-disability increases in her disability benefits and of the benefits paid to her on account of her dependent children. Petitioner does not challenge respondent's right to offset the dollar amount of primary disability benefits to which she became entitled upon first qualifying for Social Security—only the subsequent increases in those benefits.

REASONS FOR GRANTING THE WRIT

This Petition raises important questions of federal law which have not been, but should be, settled by this Court. Petitioner asserts that the first clause of Section 207 of SSA, 42 U.S.C. § 407, prohibits the transfer or assignment, at law or in equity, to an insurance company of the right of Social Security recipients to future increases in their primary disability benefits once they have qualified for benefits both under SSA and under private disability insurance plans. Petitioner also asserts that the public policy underlying Sections 207 and 202(d)1 of SSA, 42 U.S.C. §§ 407, 402(d)1, prohibits the deduction from disability insurance proceeds of Social Security child's insurance benefits paid to disabled persons as representative payees of their dependent children.

These issues are as novel and significant as those resolved by the Court in *Philpott v. Essex County Welfare Board*, 409 U.S. 413 (1973), which interpreted the second clause of Section 207 to prohibit creditors from reaching monies paid or payable, or rights existing, under SSA. Because no decision by this Court has heretofore interpreted the first clause of Section 207, this Petition provides an opportunity, nearly 50 years after SSA's passage, for the Court to delineate the reach of the statute's spendthrift provisions—an interpretation which will affect literally millions of participants in group long term disability insurance plans.

A. The Decision of the Third Circuit Raises Questions of First Impression and Paramount Importance Concerning the Entitlement of Disabled Social Security Recipients and Their Dependent Children to Legislated Benefits Under the Social Security Act

The decision of the Third Circuit in this case denies to the disabled and their dependents the safety net of public benefits that Congress has jealously guarded

against encroachment over more than four decades of Social Security policy-making. The decision below interprets the Social Security Act in a manner that this Court has never previously countenanced and that endangers the economic well-being of a nationally significant class of Social Security beneficiaries.[11]

As an exercise in government administration, the Social Security program is of unparalleled scope. For example, in 1977, the year in which petitioner brought suit, approximately 150 million claims were filed[12] and more than 34 million persons received benefits under the old-age, survivors and disability insurance program.[13] Nearly five million of these persons were disabled workers and dependents in current-payment status during 1977.[14] The aggregate benefits paid to the disabled and their dependents during 1977 exceeded 10 billion dollars.[15]

As the Court has observed, "[g]iven this magnitude, the number of times these SSA claims have reached this

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[11] Information developed before the District Court showed that as of June 1978, there were approximately 10,000 disabled persons insured by respondent in current-payment status and that there were approximately 12,000 other disabled insureds who were formerly in payee status but who had reached the age of 65, died or whose insurance benefits otherwise were terminated. Lamb Affidavit (June 5, 1978), at 4. The record developed below also showed that some 498,000 workers were insured under respondent's disability insurance policies. *Id.* While it is impossible to calculate the precise number of these persons and persons similarly situated insured by other carriers who may be affected by the disposition of this case, that number is national in scope.

[12] Social Security Administration Office of Management and Administration, The Year in Review, The Administration of Social Security Programs 1977, at ii (July 1978).

[13] Department of Health and Human Services, Social Security Administration, Social Security Bulletin, at 41 (April 1981).

[14] *Id.* at 50.

[15] *Id.*

Court warrants little surprise." *Califano v. Boles*, 443 U.S. 282, 283 (1979). Time and again, the Court has intervened to ensure that program beneficiaries receive the benefits to which they are entitled by law.[16] These decisions reflect this Court's special sensitivity to the congressional intent to afford protection to families against the economic hardships occasioned by old-age, death and disability.

The Third Circuit's decision breaks faith with the nation's disabled workers and deprives them of the benefit of increases in Social Security payments which they depend on to maintain their life standard and which Congress has determined are necessary to cope with the increasing cost of living. According to the Third Circuit,

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[16] *See, e.g., Califano v. Jobst*, 434 U.S. 47 (1977) (termination of dependent child's benefits upon his marriage); *Califano v. Webster*, 430 U.S. 313 (1977) (gender-based differences in benefit computation); *Califano v. Goldfarb*, 430 U.S. 199 (1977) (gender-based differences in defining dependent of deceased wage earner); *Mathews v. De Castro*, 429 U.S. 181 (1976) (denial of "wife's insurance benefits" to divorced women); *Norton v. Mathews*, 427 U.S. 524 (1976) (illegitimate children denied presumption of dependency); *Mathews v. Lucas*, 427 U.S. 495 (1976) (same); *Weinberger v. Salfi*, 422 U.S. 749 (1975) (duration-of-relationship requirements of receipt of mother's or child's insurance benefits); *Weinberger v. Wiesenfeld*, 420 U.S. 636 (1975) (gender-based denial of survivor's benefits to widows); *Jimenez v. Weinberger*, 417 U.S. 628 (1974) (denial of disability insurance benefits to illegitimate children born after date of wage earner's disability); *Richardson v. Belcher*, 404 U.S. 78 (1971) (reduction in Social Security benefits to reflect state workmen's compensation benefits); *Flemming v. Nestor*, 363 U.S. 603 (1960) (termination of insurance benefits to aliens upon deportation). *See also Califano v. Yamasaki*, 442 U.S. 682 (1979) (necessity for oral hearing prior to recoupment in overpayment matters); *Mathews v. Eldridge*, 424 U.S. 319 (1976) (necessity for evidentiary hearing before termination of disability insurance benefits); *Richardson v. Wright*, 405 U.S. 208 (1972) (procedures used in suspending or terminating disability benefits); *Richardson v. Perales*, 402 U.S. 389 (1971) (requirement of "substantial evidence" to support denial of benefits).

these increases may effectively be appropriated by disability insurance carriers to reduce insurance benefits otherwise payable by them to disabled recipients.

Significant sums are involved. Since 1972, Congress has repeatedly legislated increases in the level of benefits due Social Security disability recipients.[17] In 1972, benefits were adjusted upward by 20 percent.[18] In 1973, Congress increased benefits payable in 1974 by 11 per cent.[19] Further increases have resulted from application of the formula enacted by Congress to index benefits to the rising cost of living.[20]

Between 1971 and 1980, the petitioner alone became entitled to more than $10,000 in increased payments which were lost to her because of respondent's practice of deducting these increases from her insurance proceeds. The Third Circuit acknowledged the "inequity" of this shift in economic benefits (App. 12a), but refused to apply the anti-assignment and transfer provisions of Section 207 as the instrument for remedying it.

Furthermore, the decision below impairs Congress' intent in legislating Social Security benefits for the use and benefit of dependent children of disabled workers. Section 202(d)1 of SSA, 42 U.S.C. § 402(d)1, provides that "[e]very child . . . of an individual entitled to . . . disability insurance benefits . . . shall be entitled to a child's

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[17] The legislative history of these measures makes clear Congress' intent that legislated increases in program benefits go to maintain the living standard of program beneficiaries against escalations in the cost of living. *See, e.g.*, H.R. Rep. No. 627, 93rd Cong., 1st Sess. 3-5, 23-25 (1973); H.R. Rep. No. 1215, 92nd Cong., 2nd Sess. 21 (1972); 119 Cong. Rec. 36952 *et seq.* (1973); 118 Cong. Rec. 23286 *et seq.* (1972).

[18] Act of July 1, 1972, Pub. L. No. 92-336, 86 Stat. 406.

[19] Act of December 31, 1973, Pub. L. No. 93-233, 87 Stat. 948; Act of July 9, 1973, Pub. L. No. 93-66, 87 Stat. 153.

[20] 42 U.S.C. § 415(i).

insurance benefit." Implementing regulations provide that dependent children's benefits are received "only for the use and benefit of such [dependent] beneficiary" (20 C.F.R. § 404.1603), and are "to be conserved for the child, most often to pay for education." *Garvey v. Worchester Housing Authority*, 629 F.2d 691, 692 (1st Cir. 1980). Under the Third Circuit's view, however, the economic benefit of these payments is misdirected to private insurers.[21]

In this regard, the decision below conflicts with the rationale of *Johnson v. Harder*, 383 F. Supp. 174 (D. Conn. 1974), *affirmed per curiam*, 512 F.2d 1188 (2d Cir.), *cert. denied*, 423 U.S. 876 (1975). In that case, state welfare officials relied on a state regulation to offset against plaintiff's welfare payments Social Security benefits received by plaintiff for the "use and benefit" of her dependent children. The court enjoined enforcement of the regulation on the ground that the Social Security Act and regulations prohibited the application of plaintiff's dependent's benefits to reduce welfare payments to which she was otherwise entitled. The same reasoning calls into question the deduction of petitioner's dependents' benefits here.

In denying petitioner the benefit of her Social Security entitlements, the court below echoed the familiar refrain that if Congress had intended to prohibit the reduction of Social Security benefits by private disability insurance carriers, it could have so provided. Actually Congress did strike the balance in favor of program recipients. Section 224a of SSA, 42 U.S.C. 424a, carves out an

[21] In reaching this result, the Third Circuit misread *Garvey*, failing to recognize that the holding in that case represented only an exception to the general rule prohibiting the deduction of dependent children benefits from other public and private insurance benefits payable to permanently disabled persons, which exception was based on a countervailing federal policy reflected in HUD regulations covering the same subject matter.

exception for the deduction of worker's compensation benefits from Social Security disability payments. This provision was added to SSA in 1965 in order to prevent "excessive combined benefits." S. Rep. No. 404, 89th Cong., 1st Sess. at 100. But workmen's compensation awards are the *only* offset authorized under Section 224a. Reductions for private disability insurance and even monetary recoveries in civil tort suits are not permitted—even though workmen's compensation programs are also financed privately and serve precisely the same function as other forms of disability insurance and tort damage suits.

The intent of Section 224a is to allow disabled workers, except those receiving workmen's compensation benefits, to realize the combined benefit of what they are due under Social Security *and* what they are entitled to under private disability insurance. Congress may, of course, find that the distinction it has drawn is undesirable. If so, it may engraft onto the statute additional exceptions allowing for the offset of other forms of disability insurance. For the present, however, the offset of benefits accomplished by respondent in this case and sanctioned by the court below "promises to diminish that portion of the benefit Congress has said should go to the . . . worker alone, and threatens to penalize one whom Congress has sought to protect." *Hisquierdo v. Hisquierdo*, 439 U.S. 572, 590 (1979).

B. The Decision of the Third Circuit is Incompatible With Prior Decisions of This Court

Wholly aside from the importance and novelty of the questions presented, the decision below merits consideration in this forum because it is incompatible with prior decisions of this Court interpreting the scope and operation of 42 U.S.C. § 407 and similar anti-assignment statutes. Section 407 forbids assignment or transfer of

future Social Security benefits and the use of legal process to reach them. The purpose of the provision is "to protect funds granted by the Congress for the maintenance and support of the beneficiaries thereof." *Porter v. Aetna Casualty & Surety Co.*, 370 U.S. 159, 162 (1962) (veterans' benefits). The prohibition is unqualified and unambiguous.

In the face of the statute's absolute prohibition, the Third Circuit drew a distinction between what it termed "theoretical" assignments of Social Security benefits (which are permitted) and actual assignments (which are forbidden). App. at 7a. This distinction is not found in the statute and serves only to cloud legislative intent and to deflect federal policy away from the intended goal.

The Third Circuit's interpretation of Section 207 imparts to the terms "assignment" and "transfer" a meaning that unduly restricts the statute. Such statutory terms are to be read in the light of customary understanding at the time of enactment unless the contemporaneous legislative discussion suggests a special meaning. *St. Paul Fire & Marine Insurance Co. v. Barry*, 438 U.S. 531, 545-46 (1978). The terms used in Section 207 were understood at the time Congress enacted SSA and preclude the diversion of program benefits sanctioned by the court below.[22] Indeed, the statute's purpose of preventing

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[22] The assignment of petitioner's Social Security benefits sanctioned below is "equitable" in nature. The express terms of Section 207 ("at law or in equity") prohibit such assignments, which both the Third Circuit and New Jersey courts have defined as "the actual or constructive appropriation" of "not only . . . choses in action and of contingent interests and expectancies, but 'also of things which have no present actual or potential existence, but rest in mere possibility . . .'" *Eisenlohr v. Ehrich*, 296 F. 816, 819-20 (3d Cir.) (quoting Story's Equity Jurisprudence), *cert. denied*, 265 U.S. 584 (1927); *Hackensack Trust Co. v. Ackerman*, 47 A.2d 832, 838 (N.J. Eq. 1946) (equitable assignment evidenced

dissipation of benefits invites the broadest construction. And the Third Circuit should not have been misled by the absence of contemporaneous legislative discussion on the particular issue, because "if Congress has made a choice of language which fairly brings a given situation within a statute, it is unimportant that the particular application may not have been contemplated by the legislators." *Barr v. United States*, 324 U.S. 83, 90 (1945).

This Court recently confirmed the broad construction to be given Section 207 in *Philpott v. Essex County Welfare Board*, 409 U.S. 413 (1973). There, the Court found "[t]he language is all-inclusive," and the prohibition "broad enough to include all claimants, including a State." *Id.* at 415, 417. In answering a claim that the State be allowed to offset local benefits by the amount of the federal grant, the Court stated:

> We see no reason to base an implied exemption from § [2]07 on that ground. We see no reason why a state, performing its statutory duty to take care of the needy, should be in a preferred position as compared with any other creditor. (*Id.* at 416).

This perspective was reinforced in *Hisquierdo v. Hisquierdo*, 439 U.S. 572 (1979), which involved parallel anti-assignment provisions in the Railroad Retirement Act, 45 U.S.C. § 231m.[23] There again, the Court cau-

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by "an assignment even though of a future interest, as in after acquired property"); *Stokeley Bros. & Co. v. Conklin*, 26 A.2d 147, 152 (N.J. Eq. 1942) ("The fund need not be actually in being if it exists potentially"). *See also duPont de-Bie v. Vredenburgh*, 490 F.2d 1057, 1060 (4th Cir. 1974); *Wolters Village Management Co. v. Merchants & P. Nat'l Bank*, 223 F.2d 793, 798 (5th Cir. 1955); *Cook v. Commercial Cas. Ins. Co.*, 160 F.2d 490, 493 (4th Cir. 1947).

[23] In language similar to Section 207 of SSA, 45 U.S.C. § 231m provides in relevant part:

> Notwithstanding any other law of the United States or of any State, territory or the District of Columbia, no annuity

tioned against "discard[ing] the settled view that anti-assignment statutes have substantive meaning." *Id.* at 586. The Court found that these provisions were designed not only to "ensur[e] that the benefits actually reach the beneficiary," but also to keep "the vagaries of state law from disrupting the national scheme, and guarante[e] a national uniformity that enhances the effectiveness of congressional policy." *Id.* at 584.

Contrary to this Court's teaching in *Philpott* and *Hisquierdo*, the decision below places the parochial interests of state contract law above national policy, and undermines Section 207's guarantee that program benefits reach their intended beneficiaries unencumbered by the claims of third parties. The Third Circuit's decision also undermines the goal of national uniformity referred to in *Hisquierdo*. At present, in some jurisdictions, state legislation restricts the deduction of program payments that disability carriers can make from the insurance benefits due disabled workers,[24] so that disabled recipients receive the full economic benefit of their Social Security entitlements. In other jurisdictions, however, the benefit

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or supplemental annuity shall be assignable, . . . nor shall the payment thereof be anticipated.

The two statutes also share the same goal of "'mak[ing] it sure that the annuitant gets the pension.'" 439 U.S. at 576 n.7. Moreover, the Railroad Retirement Act "was amended several times to make it conform more closely to the existing Social Security Act." *Id.* at 574 n.3. Other similarities between the two statutes were noted by the Court. *Id.* at 575 n.6, 584.

[24] *E.g.*, Cal. Ins. Code § 10127.1 (West Supp. 1981); Conn. Gen. Stat. Ann. § 38-174i; (Supp. 1980); Ga. Code Ann. § 56-3409b (Supp. 1980); Hawaii Rev. Stat. § 431-521(c) (Supp. 1979); Ill. Ann. Stat. ch. 73, § 967.1 (Smith-Hurd Supp. 1980); Md. Code Ann. art. 48a §§ 240H, 477G (1979); Minn. Stat. Ann. § 62A.18 (Supp. 1981); Pa. Stat. Ann. tit. 40, § 754.1 (Purdon Supp. 1980); S.D. Comp. Laws Ann. § 58-18-11.1 (1978).

of these payments inures to private insurers. The decision below preserves this patchwork system of distributing federal benefits.

Finally, the Third Circuit's holding in this case detracts from this Court's decisions interpreting analogous anti-assignment statutes[25] to void, as between private parties, the voluntary transfer of claims against the government.[26] These cases read the anti-assignment provisions as invalidating such transfers, except where the government has paid the claim or, for other reasons, is no longer substantially interested in the matter. *Segal v. Rochelle, supra,* 382 U.S. at 384; *Martin v. National Surety Co., supra,* 300 U.S. at 594-97. The transfer and assignment sanctioned in this case involves claims to benefits which remain periodically payable to petitioner over time, and which the government pays under a program designed expressly to protect petitioner and her dependents from the hardship entailed by her disability.

In summary, neither the language and policy of SSA, nor the prior decisions of this Court, support the Third Circuit's judgment that private insurers may deduct Social Security disability benefit increases and dependent children's benefits from the proceeds owed to Social Security recipients under private disability insurance policies. This Court should review the decision below in order to

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[25] Section 207 of SSA is one of a number of federal statutes that regulate the assignment of federally conferred benefits. *E.g.,* 16 U.S.C. § 590h(g) (conservation benefits); 22 U.S.C. § 1004(c) (foreign service officer retirement benefits); 31 U.S.C. § 203 (claims against United States); 35 U.S.C. § 261 (patents); 42 U.S.C. § 1473 (farm loans); 45 U.S.C. § 231m (railroad retirement benefits).

[26] *Segal v. Rochelle,* 382 U.S. 375 (1966); *Martin v. Nat'l Surety Co.,* 300 U.S. 588 (1937); *Houston v. Ormes,* 252 U.S. 469 (1920); *Nat'l Bank of Commerce v. Downie,* 218 U.S. 345 (1910).

ensure that the economic benefit of these Social Security entitlements reaches their intended beneficiaries.[27]

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[27] Seen in context, this petition presents for review the latest in a related trilogy of decisions by the Third Circuit denying pension and disability insurance benefits to the retired and permanently disabled. The first two of these decisions, *Alessi v. Raybestos-Manhattan, Inc.*, 616 F.2d 1238 (3d Cir. 1980), *probable jurisdiction noted*, No. 79-1943 (U.S. November 3, 1980), *affirmed*, 49 U.S.L.W. 4503 (1981); *Buczynski v. General Motors Corporation*, 616 F.2d 1238 (3d Cir. 1980), *cert. granted*, No. 80-193 (U.S. November 3, 1980), *affirmed*, 49 U.S.L.W. 4503 (1981) [hereinafter cited as "*Alessi-Buczynski*"], recently affirmed by this Court, sanctioned under ERISA the practice of private employers in reducing vested pension benefits owed to retired workers under federally regulated pension plans by the amount of subsequent workmen's compensation awards. Review of the decision below is appropriate because the Court's decision in the first two cases in the series leaves uncertain the legality of the related practice upheld in the case at bar.

This Court's analysis in *Alessi-Buczynski* contrasts with that used by the Court below to validate the integration of Social Security benefits and insurance proceeds. *Alessi-Buczynski* involved statutory provisions which neither expressly precluded nor authorized the integration of workmen's compensation benefits and vested pension benefits. In interpreting ERISA to validate the offset of such benefits, the Court had explicit Congressional approval of the practice of integrating pension benefits and retirees' collateral sources of income. 49 U.S.L.W. at 4506. The Court also relied on IRS rulings, which predated passage of ERISA and which Congress knew permitted the integration of pension benefits and workmen's compensation awards. *Id.* at 4507. The absence of evidence of legislative intent of the type that governed in *Alessi-Buczynski* leaves uncertain the analogous practice of integrating federal and private disability benefits.

CONCLUSION

For the foregoing reasons, this Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 80-1523

ANNELIESE B. LAMB, individually and on behalf of all other persons similarly situated,
Appellant

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY, a Corporation of the State of Connecticut

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ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY
C.A. No. 77-1290

Argued December 4, 1980

Before: ADAMS, GARTH and SLOVITER, *Circuit Judges*

(Filed February 23, 1981)

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OPINION OF THE COURT

ADAMS, *Circuit Judge.*

This appeal presents two related questions: first, whether Section 207 of the Social Security Act, 42 U.S.C. § 407 (1976), prohibits the defendant, Connecticut General Life Insurance Company [CGLIC], from offsetting Social Security disability benefit increases received by the disabled plaintiff, Annaliese Lamb, against the benefits payable to the plaintiff under the terms of a group disability insurance policy; and second, whether the public policy expressed in Section 202 of the Social Security Act, 42 U.S.C. § 402 (1976), forbids the additional offset against Lamb's disability insurance benefits of Social Security benefits payable to her dependents. We conclude that neither of these offsets is unlawful under the Social Security Act, and therefore affirm the district court's grant of summary judgment to the defendant.

I.

In 1969, Lamb's employer, Overlook Hospital, purchased a group long-term disability policy from CGLIC that covered certain enrolled employees, including Lamb. The policy provided covered employees who became disabled with a monthly income payment equal to 70% of the monthly income they had earned while employed. Payments under the plan were reduced by "Other Income Benefits" payable to the disabled employee, including Social Security disability benefits, so that the total of insurance payments and "Other Income Benefits" always equalled 70% of the employee's previous monthly earnings.[1]

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[1] The insurance policy between Overlook and CGLIC, and the Certificate of Insurance received by Lamb, contained the following pertinent provisions:

[Footnote continued on page 3a]

Lamb became permanently disabled within the meaning of the CGLIC plan in January, 1971. On June 30, 1971 she was found to be eligible for Social Security disability benefits for both herself and her dependents. Consequently, CGLIC adjusted her monthly income benefits to reflect the Social Security benefits that she received for herself and her dependents. Thereafter, as Social Security benefits have increased to keep pace with the cost of living, CGLIC has reduced by an equivalent amount the Monthly Income Benefits it pays to Lamb. The result is that to date Lamb receives the same gross amount each month that she received in 1971.

Objecting to the way in which the CGLIC plan prevented her total income from rising with inflation, Lamb filed suit against CGLIC, charging that the insurance company fraudulently induced her to join the group plan through misrepresentations in the information it supplied to Lamb and the other employees. In addition, Lamb complained that the offset of Social Security disability benefit increases against the policy payments violated 42

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[1] [Continued]

> The amount of Monthly Income otherwise payable for any monthly period will be reduced by the amount of all Other Income Benefits . . . for the same monthly period.
>
> * * *
>
> Other Income Benefits include:
>
> (1) any periodic cash payments provided on account of employee's disability;
>
> * * *
>
> (b) by the Federal Social Security Act, including benefits payable to the employee's dependents on account of the employee's disability;
>
> * * *

The employer could have selected another plan that did not offset Social Security benefits in this fashion. Because CGLIC considered "Other Income Benefits" in its actuarial calculations, however, the premium under this other option would have been significantly higher.

U.S.C. § 407, which interdicts assignment, transfer, execution or other legal attachment of future Social Security benefits. Lamb also alleged that the reduction of CGLIC benefits in proportion to the amount of Social Security payments she received for her dependents under 42 U.S.C. § 402 violated the public policy underlying that section. Finally, she asserted claims for statutory penalties under the Welfare & Pension Plan Disclosure Act (WPPDA), 29 U.S.C. § 50 *et seq.*, and the Employment Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*

The district court recognized that neither WPPDA nor ERISA applies to this disability plan, and dismissed the final allegation asserted by Lamb. It also granted summary judgment to the defendant on the question of illegal offsets. Determining that the fraud counts were state law claims, and that he had discretion not to exercise pendent jurisdiction after disposing of all federal law claims, the district judge dismissed these counts without prejudice to the right of the plaintiff to bring an action in state court relating to the fraud claims. On this appeal, only the summary judgment award against Lamb on the offset counts is before this Court.

II.

Lamb first contends that the Social Security Act, 42 U.S.C. § 407 (1976),[2] prohibits CGLIC, as a matter of law, from deducting any increase in Social Security benefits payable to her from the amount paid to her under the insurance policy.

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[2] 42 U.S.C. § 407, reads, in pertinent part:

> The right of any person to any *future* social security payment . . . shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this title shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

(Emphasis added).

In so arguing, Lamb concedes that § 407 does not bar a "frozen" offset of Social Security benefits against amounts payable under private contracts. A frozen offset is one that is permanently fixed at the level of the recipient's initial Social Security benefits. Both state and federal law supports the validity of frozen offsets. *See Hurd v. Illinois Bell Telephone Co.*, 136 F. Supp. 125, 142 (N.D. Ill. 1955), *aff'd*, 234 F.2d 942 (7th Cir. 1956), *cert. denied*, 352 U.S. 918 (1956); *Killebrew v. Abbott Laboratories*, 352 So.2d 332, 336 (La. Ct. App. 1977), *aff'd*, 359 So.2d 1275, 1278 (La. Sup.Ct. 1978); *Williams v. Insurance Company of North America*, 150 Mont. 492, 434 P.2d 395, 397 (1967); *Voss v. Mutual of Omaha Insurance Co.*, 469 S.W.2d 602, 604 (Tex. Ct. Civ. App. 1971). *Cf. Buczyinski v. General Motors Corp.*, 616 F.2d 1238 (3d Cir. 1980), *cert. granted*, 49 U.S.L.W. 3322 (Nov. 4, 1980) (No. 80-193). In *Buczyinski*, we held that anti-forfeiture language in ERISA, 29 U.S.C. § 1053(a), did not prohibit offsetting against pension benefits the amount of a pensioner received under a New Jersey Workers Compensation statute.

Having conceded the validity of a frozen offset, however, Lamb maintains that an "unfrozen" offset, which decreases insurance payments as Social Security benefits are increased, violates the prohibition against assignment of future Social Security benefits, 42 U.S.C. § 407. She maintains that, since CGLIC reduces her insurance benefits whenever Social Security benefits are increased, it is CGLIC that enjoys the increases in Social Security benefits enacted by Congress, and not her. This, she asserts, is contrary to the intent of Congress.

Philpott v. Essex County Welfare Board, 409 U.S. 413 (1973) and *Hisquierdo v. Hisquierdo*, 439 U.S. 572 (1979), cited by appellant, do not support her argument. Both cases involved the transfer of Social Security payments to a third person through legal process. Here,

Lamb's legal right to receive her Social Security payments and the increases is uncontested. She continues to receive those benefits, and has, in fact, at all times received combined benefits from the insurance policy and Social Security in excess of what she would receive from the Social Security program alone. Thus, neither *Philpott* nor *Hisquierdo* control the question of the validity, under sections 402 and 407, of an unfrozen offset.

In recent years, there have been a number of state and federal legislative determinations to prohibit unfrozen offsets under various benefit programs, because such offsets deprive insured individuals of any real benefit from the cost of living increases in Social Security mandated by Congress. For example, unfrozen offsets against qualified pension plans are forbidden under ERISA, *see* 26 U.S.C. § 401(a)(15), as well as under the Railroad Retirement Act, *see* 29 U.S.C. § 1056(b). In addition, many states have adopted statutes or regulations dealing with the integration of Social Security benefits and health and accident policies that pay disability benefits.[3] New Jersey, however, has not yet prohibited unfrozen offsets.

Congress, in 1978, considered S.3017, which would have prohibited unfrozen offsets of Social Security benefits. Congress has not yet passed the bill, however, and, in the absence of a legislative mandate to the contrary, it does not appear that an unfrozen offset violates the letter or spirit of the Social Security Act.

This conclusion is supported by *Hurd v. Illinois Bell Telephone Co.*, 136 F. Supp. 125 (N.D. Ill. 1955) aff'd 234 F.2d 942 (7th Cir. 1956). In *Hurd*, the employer offset one-half of a worker's federal old-age insurance benefits against the amount of pensions paid to retired

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[3] *See* Dist. Ct. Op., Appendix B; App. at 637a for a compilation of the statutes and regulations of some jurisdictions.

employees. The effect of this unfrozen offset arrangement was that while the total benefits received from both Social Security and the pension increased with any Social Security benefit increase, a participant realized the benefit of only one-half of the federal increase. The district court concluded that the shift in the economic benefit of a Social Security increase from the recipient to the company did not constitute a "transfer" prohibited by § 407 of the Act. Reasoning that § 407 was directed at traditional types of assignments, whereby a recipient relinquished a portion of the federal benefits, the court found the fact that the workers received their full Social Security allotment to be dispositive. As the district court noted, § 407 "was never intended to freeze a worker's private pension at a particular level. It was concerned only with guaranteeing that the worker would actually receive for his own use the amount due him under the Social Security Act." 136 F. Supp. at 142. Finally, the court cited legislative history which indicated that Congress anticipated that private companies would integrate Social Security benefits with the amounts paid under private insurance programs.

The reasoning of the district court in *Hurd* appears to have considerable force. Here, the fact is that Lamb receives her full entitlement from the Social Security program. She has not transferred any portion of her federal benefits to the insurance company. Since § 407 does not address itself to the level of benefits that a private insurance program must pay to augment federal programs, we cannot say that the CGLIC insurance contract runs afoul of the anti-transfer provision of the Social Security Act.

Although it may appear inequitable that CGLIC is, in a theoretical sense, receiving the benefit of cost-of-living increases under the Social Security Act by diminishing the amounts it pays, Congress, rather than the

courts, should attend to this problem. Lamb may also seek to attack the harsh affect of the insurance contract by asserting state law claims founded on misrepresentation or unconscionability of the contract. Federal law, however, currently does not prohibit unfrozen offsets against Social Security benefits that do not impact the level of funds the insured receives from the federal government.

III

The insurance policy offsets not only Lamb's own Social Security benefits, but also the Social Security benefits she receives for the support of her dependents. Lamb argues that this latter provision violates the policy underlying the section of Social Security Act providing disability benefits to dependent children, 42 U.S.C. § 402(d)(1).[4]

To support her position, Lamb relies primarily upon *Coughlin v. CGLIC*, 330 A.2d 159 (Del. Super. 1974). In *Coughlin*, the court held, as a matter of *state law*, that the language of the disability insurance policy did not require the offset of payments made to the plaintiff's children against the benefits payable to plaintiffs under the policy. Because *Coughlin* did not involve federal law, however, it has no bearing on Lamb's argument, which is predicated on the Social Security Act.

The district court held that the offset of payments received by Lamb's dependents on accounts of her disability does not transgress the policy undergirding the Social Security Act, 42 U.S.C. § 402. There is nothing in § 402(d)(1) to suggest that it prevents an employer from bargaining for an insurance contract to cover its employees that offsets Social Security benefits received

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[4] 42 U.S.C. § 402(d)(1) provides, in part:

> Every child . . . of an individual entitled to . . . disability insurance benefits . . . shall be entitled to a child's insurance benefit.

for the support of dependents against the disability payments to be made under the policy. Similar to § 407, § 402(d)(1) is not addressed to the level of payment that must be maintained by a private insurance company. Thus, we cannot disagree with the conclusion of the district court.

Support for the conclusion reached by the district court may be found in *Dowell v. Aetna Life Insurance Co.*, 468 F.2d 802 (4th Cir. 1972), *cert. denied*, 410 U.S. 931 (1973), as well as in the recent decision of the First Circuit in *Garvey v. Worchester Housing Authority*, 629 F.2d 691 (1st Cir. 1980). In *Dowell*, the court upheld the validity of a contract offsetting Social Security disability benefits made to the plaintiff's wife and children against contractual disability insurance benefits paid to the plaintiff. 468 F.2d at 804-05. In *Garvey*, a nationwide class of residents of public housing sought declaratory and injunctive relief to prevent the Department of Housing and Urban Development from considering the Social Security benefits of minors as family income, for the purpose of computing rent levels for such public housing. The court affirmed the validity of HUD's practice of including minors' benefits when computing family income. These cases demonstrate that total family income, including dependents' Social Security allotments, rather than just individual income, may be considered when calculating benefit levels under public or private support programs.

For the foregoing reasons, we find that the terms of the Social Security Act prohibit neither of the offsets authorized by the CGLIC group disability plan. Although the Social Security Act as is now stands mandates this conclusion, the result appears somewhat incompatible with the overall intent of Congress in voting to augment the level of benefits. The purpose behind these cost of living increases is to alleviate the harsh impact of inflation on the elderly and the disabled. Yet, by virtue of the

CGLIC policy, Lamb's income has remained fixed despite a dramatic rise in the cost of living since 1971.

Lamb's predicament evokes sympathy. But courts are constrained to apply the law as adopted by the legislature, within the limits set by the Constitution, and Congress has not yet acted to ban unfrozen offsets of social security benefits. It is the province of Congress, rather than the courts, to change existing law when social or economic conditions demand adaptation. Accordingly, we can only urge Congress to devote prompt attention to the unfortunate impact on disabled Social Security recipients of insurance arrangements such as the CGLIC disability plan.

The judgment of the district court will be affirmed.

A True Copy:

Teste:

Clerk of the United States
Court of Appeals
for the Third Circuit

APPENDIX B

Opinion Filed March 4, 1980

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW JERSEY

Civil 77-1290

ANNELIESE B. LAMB,
Plaintiff,

vs.

CONNECTICUT GENERAL LIFE INSURANCE CO.,
Defendant.

Appearances:

Hebert H. Jaffe, Esq.
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Eugene M. Haring, Esq.
(McCarter & English, Esqs., Newark) for defendant

OPINION

BIUNNO, District Judge.

This case comes before the court on defendant's motion for summary judgment addressed to the Amended Complaint, and plaintiff's cross-motion for partial summary judgment in her favor on the Third Count of the Amended Complaint. For reasons to be stated, defendant's motion will be granted in part, i.e., insofar as the Amended Complaint attempts to advance federal claims (to be described); and as to any subsumed State claims, the remainder of the Amended Complaint will be dismissed for lack of jurisdiction under F.R.Civ.P.12(h)(3) on the court's own motion. Plaintiff's cross-motion for partial summary judgment on Count 3 will be denied.[1]

[1] The judgment in favor of defendant is on the merits of its motion and is with prejudice. The dismissal of the State law claims is for lack of jurisdiction, is not on the merits, and plaintiff is free to press such claims in any State court of competent

The nature of the claim, as well as the applicable law, requires a review of the factual background and the steps taken in the case.

It appears not to be in dispute that plaintiff Lamb was employed as a dietician at Overlook Hospital in New Jersey at a time when Overlook negotiated with Connecticut General Life Insurance Co. (CGLIC) a proposed group policy to provide benefits for long-term disability to those employees who wished to participate.[2] Overlook distributed literature about the proposal to its employees, and meetings were held at which Overlook personnel explained the proposal. Each employee was also provided

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jurisdiction. Since nothing remains to be decided here, the judgment is final.

In neither the original nor the amended complaint is there a claim of diversity jurisdiction, although pendent jurisdiction is asserted. There being no basis for any federal claim, the court exercises its discretion to dismiss the pendent state claims.

[2] The discovery record shows without dispute that Overlook, through an insurance broker, negotiated with CGLIC to resolve the selection of various types of coverage, benefits and terms of the group policy. Overlook then proposed the arrangement to the employees in the group, who numbered 93, and of which 70 decided to participate. No evidence was adduced to show that CGLIC ever dealt with any Overlook participant before the policy was written. The majority rule is that the group policyholder acts for itself and on behalf of the members of the group; it is not the agent of the insurance carrier. New Jersey adheres to the majority rule. *Mariotti v. Metropolitan, etc.*, (22 N.J.L. 360 (E & A, 1939); *Boseman v. CGLIC*, 301 U.S. 196 (1937).

See, also, *Keane v. Aetna Life Ins. Co.*, 22 N.J.Super. 296 (App., 1952) where suit was against both the insurer *and* the employer, the latter having failed to pay premiums and to notify the employee of the termination of coverage or of a potential right to convert his group coverage to individual. Because of certain fact issues, a summary judgment below was set aside and no later report indicates the final outcome.

See, also, New Jersey State Bar Examination, February 28, 1980, Question 3.

with a sheet indicating the premium contribution and the level of benefits as calculated at that time, and each employee was provided with a form on which to indicate the desire to participate. Lamb, and enough other employees having indicated a desire to participate, the group policy was written by CGLIC and issued to Overlook, while certificates of coverage were issued to participating employees.[3]

Thereafter, and while covered, Lamb became disabled as defined by the contract, and applied for benefits, which were approved after the contract waiting period.

In this same period, it appears that Lamb also applied for disability benefits under the Social Security Act and that she was found to have an impairment qualifying as a "disability" as defined by law, and the statutory benefits were granted.[4]

The CGLIC contract expressly provided for an "offset" for benefits from collateral sources. The amount of the monthly income benefits begins as 70% of the employee's monthly "Basic Earnings" (i.e., the rate of pay excluding overtime, bonus or additional compensation based on the normal work week of not more than 40 hours), subject to a ceiling of $1,500. per month in benefits. The monthly

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[3] The record shows, including discussion at argument of the motions, that the certificate was as explicit as the master policy in the respects at issue.

[4] No record was made of the certificate of award of Social Security disability benefits, or of agency notices to remove a dependent child who became disqualified by age, or other like changes. However, none of these data are disputed. After the waiting period on the claim, the first check sent on June 15, 1971 was for a lump sum going back to the first date when payment was due, and the accompanying letter made clear that this would be adjusted when the exact amounts of the offset were known. Additional payment was sent June 30, 1971, to adjust, and then monthly thereafter.

income benefits are adjusted, this being a reduction by the amount of "Other Income Benefits", a defined term, except that in any event minimum benefits of $50. per month will be paid regardless of the offset otherwise applicable.

"Other Income Benefits" is defined as including any periodic cash payments "provided *on account of* the employee's disability", under five specific subdivisions, as well as payments of Federal Old Age Benefits provided under the Federal Social Security Act. [emphasis added]

The five categories of collateral source payments provided on account of the employee's disability are:

(a) under any group insurance coverage;

(b) by the Federal Social Security Act, including benefits payable to the insured's dependents on account of the employee's disability;[5]

(c) by any state or federal government disability or retirement plan;

(d) under any pension plan with respect to which the employer contributes or makes payroll deductions;

(e) under or on account of any workmen's compensation or similar law;

any one or more of which became payable on or after the commencement of the disability for which the

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[5] This offset is limited to federal disability benefits paid to dependents "on account of" the disability of the covered individual. While the statutory provisions are quite complex, it is clear that certain dependents may be entitled to disability benefits due to *their own* disability through the social security coverage of the worker. Among these there is provision for such benefits to an unmarried child, 18 or over, who was severely disabled before age 22 and who continues to be disabled. The record is clear that no benefits "on account of" a dependent child's *own* disability is involved here.

"Monthly Income" benefit is provided under the group policy.

Lamb's benefits under the group policy, calculated at 70% of her "basic earnings", were adjusted by deducting the amount provided each month by the Social Security Administration as primary benefits and as dependent's benefits, on account of Lamb's disability, and there is no dispute that CGLIC has regularly paid, and is paying, the difference. Also, from time to time, the Congress has increased these benefits payable on account of Lamb's disability, and the adjustment has been made by a reduction or offset against the 70% level by the increased amounts so provided by that collateral source.

The court notes, in passing, that so far as the group policy is concerned, the point will sooner or later be reached, as to each dependent child, when federal benefits will be reduced. As that occurs, the amount of the offset will be reduced and the net or adjusted monthly amount payable by CGLIC will increase.[6]

Also, it is noted in passing that under explicit provision of the Social Security Act, the Congress reserved authority to reduce or eliminate benefits, and may repeal the entire Act.[7]

Judicial notice is also taken that in the current session, both Houses have passed a bill that, if enacted, would

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[6] Exhibit P-9 marked at Lamb's deposition de bene esse of December 12, 1978, indicates that the dependent child "Chris" was terminated by Social Security in March, 1976. While no list of names or ages was provided, the other children either have been or will be terminated by Social Security as they reach age 18 (or age 22 if full time students) and the CGLIC payment will increase accordingly.

[7] See 42 U.S.C. § 1304, referred to by the Supreme Court in *Hisquierdo*, footnote 6. It expressed the same view as to the Railroad Retirement Act.

reduce the amounts payable as disability benefits under the Social Security Act to eligible claimants who become disabled hereafter. Senate amendments differ from the House bill, and it will need to go to conference. What, if anything, will be passed and enacted is naturally unpredictable at this time. See H.R. 3236 and legislative history thereof.

In any event, the claim is cast in several forms, each of which is aimed at the offset or integration provision in the group policy: [8]

1. no offset for disability benefits may be made because of a provision in the Social Security Act foreclosing assignments, executions, and the like;

2. benefits provided as dependency benefits may not be offset because they belong to the dependents and not to Lamb;

3. increases in benefits to provide cost-of-living adjustments may not be offset because to do so would defeat the Congressional intent to moderate the impact of inflation.

The original complaint as filed claimed jurisdiction for the First Count under 28 USC § 1337 (civil actions arising under any Act of Congress regulating commerce) or 28 USC § 1331 (federal question). The federal questions were said to arise under the Social Security Act, 42 USC § 301, et seq., and under the Welfare and Pension Plan Disclosure Act of 1958, 29 USC § 301, et seq. The claim asserted was one of conversion and unjust enrich-

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[8] At the argument of the motions, plaintiff recognized that there was no bar to offset, at least as to federal law, so long as the offset were "frozen". Thus, the real issue narrows down to offsets of social security *increases*. See Tr. 2/26/79 (filed, 4/16/79), p. 38 1.23 to p. 40, 1.11. However, the opinion reviews all three theories or claims.

ment by reason of deducting, from the contract benefit amount as initially integrated with Social Security disability benefits at the level then established, *later increases* in those Social Security disability benefits.

Jurisdiction was also asserted for the Second Count under ERISA, 29 USC § 1132, as a civil action by a participant or beneficiary against an administrator or fiduciary of an employee welfare benefit plan when injunctive relief is sought in addition to the monetary claim for benefits. This count was advanced on the theory that if full integration with social security—as contrasted with "frozen" integration—was allowable initially, then when ERISA was enacted September 2, 1974, the offset became "frozen" at the level then existing, and later increases could not be integrated or offset.

The original complaint was the subject of a motion for summary judgment which was granted in favor of defendant and against plaintiff on a showing that both the group policy and certificate, which dated back to late 1969, contained clear and express language for full integration with Social Security on an "unfrozen" basis, i.e., that the contract provided for payment of excess over and above whatever the Social Security disability benefits amounted to, up to a combined total equal to 70% of basic earnings when Lamb became eligible for policy benefits, and that no public policy was contravened thereby. There was also an undisputed showing that the group insurance policy was terminated in early 1972, more than two years before ERISA was enacted, and that ERISA had no application to the case.[9]

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[9] The premium rate was raised in 1971, after the disabling event to Lamb, and Overlook chose to cancel the policy as of January 9, 1972, after Lamb was in payee status. See Tr. 2/26/79, p.33, l.3 to 17; Exh. D-1 at Lamb deposition of 12/12/78. The record is silent on the question whether Overlook replaced the terminated policy with another one, as a means for providing benefits under

The motion for summary judgment was granted with leave to file an amended complaint, and in due course that was done. A motion for summary judgment directed to the entire amended complaint was filed by defendant, and a cross-motion for summary judgment on the Third Count of the Amended Complaint was filed by plaintiff.

One of the issues argued on these motions was whether the ruling on the original complaint is res judicata on the amended complaint. Because the court is of the opinion that the motions are best addressed afresh, without confining its analysis and ruling in any way, the res judicata [illegible]t is not dealt with here.

A careful analysis of all the claims asserted, and all the undisputed facts gathered and presented through discovery and by affidavit, shows that there is no federal claim of any kind, and that if there be any claim at all, it is a state claim over which this court has no jurisdiction. Thus, the disposition on the pending motions is that summary judgment will be entered in favor of defendant and against plaintiff on all claims grounded on federal law, and insofar as any claim is asserted under state law, the complaint will be dismissed for lack of jurisdiction. This disposition leaves plaintiff free to advance whatever state law claim she may have in a state court of competent jurisdiction since the ruling on this aspect of the case is not on the merits.

Two aspects of federal law on which the claim is grounded are clearly inapplicable. These are discussed separately.

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its "Plan". The point is not significant, however, because Lamb was already in payee status when the policy was terminated, and at that time ERISA had not been enacted. Whether or not ERISA governs any later "Plan" of Overlook is irrelevant to Lamb's claims here.

The first involves the Welfare and Pension Plans Disclosure Act, enacted August 28, 1958 and amended March 20, 1962 (WPPDA), 29 USC § 301-309. This law was repealed by The Employee Retirement Security Act (ERISA), enacted September 2, 1974, in the following language:

> "The Welfare and Pension Plans Disclosure Act is repealed except that such Act shall continue to apply to any conduct and events which occurred before the effective date of this part." ERISA, Title I, Subtitle B, Part I, § 111(a)(1), 29 USC § 1031(a)(1); and the effective date of "this part" was January 1, 1975, 29 USC § 1031(b)(1).[10]

The Disclosure Act (WPPDA), was just that and no more. It was not a regulatory statute but a disclosure statute, and by design endeavored to leave regulatory responsibility to the States. Neither it nor any other combination of federal laws preempted employee welfare or pension plans. See, *Malone v. White Motor Corp.*, 435 U.S. 497 (1978).

As is well-known, with the anticipated enactment of ERISA, many employee welfare and pension plans were terminated and new ones put in force, or the earlier plans were amended, to comply with ERISA. The Minnesota statute involved in *Malone* was eventually ruled invalid as violating the Contract Clause, *U.S. Const.*Art. I., sec. 10, cl. 1, *White v. Malone*, 599 F.2d 283 (CA 8,

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[10] There are special provisions for a different effective date depending on factors not applicable here, none of which would reach back to 1972 when the policy was cancelled, or to 1971 when Lamb went on payee status, nor beyond December 31, 1974. As discussed later, the Overlook "plan", for which the CGLIC policy was obtained to provide disability benefits, was never covered by WPPDA at all, thus making the extension provision entirely inapplicable.

1979) as the result of the decision in *Allied, etc. v. Spannus*, 438 U.S.234 (1978).

The only private civil claim created by WPPDA is found in 29 USC § 308(b) and (c). These provisions subject the administrator of a plan who fails or refuses to make publication of a description of the plan or an annual report, within 30 days of a request therefor by a participant or beneficiary of the plan, to possible liability in the amount of $50. a day from the date of the failure or refusal. The requesting person may sue in any court of competent jurisdiction. The administrator may be liable in that amount "in the court's discretion", and the court may also allow a reasonable attorney's fee in its discretion. Such a claim was regarded as a claim for compensation, and not for a forfeiture, fine or penalty, in *Hales v. Winn-Dixie Stores*, 500 F.2d 836 (CA 4, 1974). The compensation, allowance of which is discretionary, is for failure or refusal to disclose and has no relation to a claim for benefits, which is what is involved here.

The second obstacle to any reliance on WPPDA is that the "administrator" of the plan involved was Overlook Hospital, the employer, not CGLIC, the insurer issuing the policy to the employer as the method for providing the benefits. This is clear from the facts not in dispute, which show that the employer, Overlook, applied for the group policy, and presented to its own employees the opportunity to participate. The policy was issued to Overlook. Overlook, as the employer, gathered the employees' contributions by payroll deduction, added its own contribution, and remitted the premiums to CGLIC. Under the statutory definition, Overlook was both the "employer" (29 USC § 302(4)) and the "administrator" (29 USC § 304(b)). It was responsible for the ultimate control, disposition or management of the money received or contributed, to wit, the employee payroll deductions and its own contribution, the total of which it was obliged

to remit as premiums paid to CGLIC. See *Wirtz v. Gulf Oil Corp.*, 239 F.2d 483 (D.Pa., 1965); *Hales v. Winn-Dixie Stores*, 500 F.2d 836 (CA 4, 1974).

The third and ultimately fatal obstacle to a claim of any kind under WPPDA is that although Overlook's plan or program to provide a disability benefits arrangement to its employees, is an "employee welfare benefit plan", as defined by 29 USC § 302(1), the coverage section, 29 USC § 303(a), expressly excludes from WPPDA an employee welfare benefit plan if

> "such plan is administered by . . . organizations described in section [s] 501(c)(3) . . . . of [the Internal Revenue] Code [of 1954]". 29 USC § 303(b)(3).

A stipulation furnished by the parties establishes that Overlook Hospital was a section 501(c)(3) organization and its name continues to appear in the "Cumulative List", issued by the Internal Revenue Service. Thus, this employee welfare benefit plan was never covered by WPPDA, that law never applied to it, and its continuance in force as to any conduct and events occurring before the effective date of Title I, Subtitle B, Part I of ERISA, has no application whatever to this case.

So far as ERISA itself is concerned, its enactment was on September 2, 1974, by which time the group policy in this case had long been terminated, Lamb was no longer an employee of Overlook and so does not come within either ERISA or any later plan which may have been put into effect by Overlook after the termination of the CGLIC group policy.

It must be realized that policies of "group" insurance are written for many kinds of groups other than those coming within an employee welfare benefit plan, or an employee pension benefit plan, whether under WPPDA or ERISA. Employees of an employer, or employees

who are members of an employee organization (such as a labor union) are but one of many kinds of "groups". Commonly, these groups are composed of persons who are members of some kind of organization without any relation to employee status. There are associations of retired persons. Their members are groups. There are holders of all kinds of credit cards. Such holders are groups. There are borrowers on mortgage or personal loans. Such borrowers, in respect to their common lending institutions, are groups. There are trade associations. Their members are groups. There are professional organizations, national, state, regional and local. Their members are groups.

All of these groups may negotiate group policies of all kinds with one or another insurer and offer participation to the members of the group. Throughout any year there is hardly a member of any "group" who does not receive in the mail some kind of application for group insurance, whether it be life, accident and health, disability, travel, hospital and medical, or the like.

None of these forms of group insurance as such, of whatever kind, have any relation to WPPDA or ERISA. They represent a method for providing insurance which, in many cases, can be obtained at rates below those for individual policies. This is not always the case because in some instances, where experience rating is applied to the group, the group premium for a member may be higher than it would be for an individual policy. This occurs most commonly with hospital, medical or dental plans, and least of all with group life, based on what is generally known.[11]

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[11] Another valuable feature of group insurance offerings, regardless of the kind of coverage or risk, is that much or all of the applicant's relevant prior history is usually waived, thus making the applicant eligible in cases where he might not be for an individual policy. The degree of waiver will usually vary with the size of the population considered for underwriting purposes, and with the size and characteristics of the group.

The group policy written by CGLIC to Overlook for the benefit of those of its employees who chose to participate, is of the same kind as the countless other group insurance policies written over the years which are not within the scope of WPPDA or ERISA, both of which cover only those plans defined by statute, some of which may have a group insurance policy of some kind as a method for providing the benefits called for by the plan.

It is worth noting, too, that welfare benefit plans and pension benefit plans are separately defined by WPPDA and carry different requirements.

A "welfare benefit plan" is one established to provide medical, surgical, hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. 29 USC § 302(1).

A "pension benefit plan", on the other hand, is one established to provide retirement benefits, including a profit-sharing plan which provides benefits at or after retirement.

Either kind of plan may provide the benefits through the purchase of insurance or otherwise. A pension plan may also provide benefits through the purchase of an annuity. The statute says so.

The disability group policy involved here would be a method of providing welfare benefits if the plan established by Overlook were covered by WPPDA. For a "welfare benefit" plan, if it were covered, Overlook would be obliged to publish (1) a description of the

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[12] The variety of "plans" is very broad. Aside from WPPDA's initial division into "welfare" or "pension" plans, which merely recognized historical development (and which is continued under ERISA), there are many other variations. Some of these are discussed in the legislative history of WPPDA cited in Appendix A, as well as the countless arrangements for groups not within either WPPDA or ERISA.

plan, and (2) an annual financial report. 29 USC §§ 304 (a); 305; 306; 307. Where benefits for a plan are provided by an insurance carrier, or by a service or other organization, the information to be supplied in the annual report of the administrator differs, depending on whether the plan is a "welfare" or a "pension" plan.[13]

For a welfare plan, the annual report is to include the information specified by 29 USC § 306(d). For a pension plan, the information in the annual report is specified by 29 USC § 306(d)(2). The detail required for pension plans includes actuarial assumptions, while that for welfare plans does not.

This distinction is noted because much is made in the pleadings, discovery and argument about actuarial assumptions underlying the premium, but even if there were a plan covered by WPPDA, which there is not, that information is not called for in the case of a welfare plan, but only for a pension plan. Having employed the term in another subdivision of the same section, Congress can hardly be assumed to have intended that it apply to both kinds of plan.

So far as the Amended Complaint is concerned, it claims jurisdiction under 28 USC § 1337 (civil actions arising out of any Act regulating commerce), by virtue of alleged violation of WPPDA and ERISA. Jurisdiction is also claimed by virtue of the Federal Declaratory Judgments Act, 28 USC §§ 2201 and 2202 and F.R.Civ. P.57, but it has long been settled that these are not

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[13] Various amendments and supplements to WPPDA were made in 1962. One of these was to require bonding of the "administrator" etc. of the "plan". 29 USC § 308d. Also, 18 USC § 1954 was added. The record is silent on the question whether Overlook complied with the bonding requirement or obtained an exemption from the Secretary of Labor. Of course, if the "plan" was not covered by WPPDA, these requirements would not apply.

jurisdictional statutes or rules. Pendent jurisdiction is also claimed, if appropriate.[14]

As in the case of the original complaint, a copy of the amended complaint was served on the Secretary of Labor and the Secretary of the Treasury under § 502(h) of ERISA, 29 USC § 1132(h) but neither has intervened.

The first count of the Amended Complaint, although alleging fraud and concealment on the part of CGLIC on the theory that materials distributed by Overlook to describe the principal terms of the proposed group coverage (added to existing life insurance, pension and annuity programs, major medical and Blue Cross/Blue Shield coverage) did not spell out that the deductions from integration with other sources specified would include the totals received therefrom including any future increases. Since a system of full integration contravenes no federal law, this count is a state law claim.[15]

The second count asserts the same claim on the assumption that if there was no malicious, fraudulent, wilful and deliberate course of conduct or scheme, then the alleged statements and omissions constitute the tort of negligent misrepresentation. This, too, is a state law claim.

The third count focuses on the deductions of allowances under Social Security for Lamb's dependents on account

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[14] The amended complaint is permeated with allegations of "principles of federal common law." So far as the State law claims are concerned, a federal common law was developed on the basis of *Swift v. Tyson*, 41 U.S. 1 (1842) but that era ended with *Erie R. v. Tompkins*, 304 U.S. 64 (1937).

[15] Where the Internal Revenue Code is not complied with, there may be federal tax consequences, of course. But those consequences do not influence the private claims asserted here and cannot change the policy terms. See, e.g., *Rothlein v. Armour & Co.*, 377 F. Supp. 506, at p. 512, item [10].

of her disability. It is neither alleged nor suggested that any dependent of Lamb is himself or herself disabled within the meaning of the Act so as to be entitled to benefits, through Lamb's status as a covered person, for the dependent's own disability.[16]

On this count, the claim is that by 42 USC § 402(d)(1) the dependent benefits belong to the dependents (though paid to Lamb) and may not be assigned by Lamb. This claim involves a federal issue to that extent.

The fourth count focuses on the theory that 42 USC § 407 forbids transfer or assignment of any "future payments", as well as executing any levy, attachment, garnishment or other legal process, etc., as to any amounts payable. This provision is said to allow integration by deducting primary benefits of Lamb's (but not dependency benefits) in the amount of the benefits to which Lamb was entitled after the contractual 6-month waiting period, but not to allow integration of increases thereafter granted under Social Security. The ensuing allegations assert that this bar is a matter of public policy under WPPDA and ERISA, and to that extent involves a federal issue, though it is intermingled with plainly state law claims.

The fifth count asserts a claim of $100 per day for the alleged failure of CGLIC to furnish information, allegedly required to be furnished by it under WPPDA, 29 USC § 306(d), and under ERISA, 29 USC § 1023(e), the request having been made September 1, 1977. The claim is said to be authorized to be brought in this court under both statutes, 29 USC § 306(b) and (c) (WPPDA) and § 1132(c) and (e) (ERISA), against the "administrator" of a plan governed by those statutes. The $100 per day rate, it is observed, is set by

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[16] See footnote 5, supra.

ERISA, but was $50. per day under WPPDA. It is further claimed that 29 USC § 308 b (WPPDA) required the administrator to retain specified records for not less than 5 years, and that by 29 USC § 1027 (ERISA) this period was enlarged to 6 years. The information sought was the computer program employed in 1969 to calculate the premium on this group policy, and CGLIC replied that it had been destroyed. This, too, is a federal issue.[17]

All five counts of the Amended Complaint are asserted not only on behalf of Lamb, but also on behalf of all others similarly situated.

The putative class (par. 32 of the first count) is identified as:

> "All persons since October, 1969 who are now or have been beneficiaries of the CGLIC Group Disability Plan sold by defendant CGLIC through employers or employee organizations and represented to provide long-term disability benefits in lieu of or as supplemental to employee welfare benefit plans and who after having been disabled and therefore qualified to receive monthly income benefits under said Plan, have had such benefits reduced by the amount of increases in social security disability benefits payable to them and their dependents pursuant to amendments to or administrative action under the Federal Social Security Act for the purpose of offsetting cost of living increases."

It is alleged that there are some 10,000 persons now in payee status under one or another CGLIC group disability policy, and that there were 12,000 persons in such status after September, 1972, who have since been

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[17] At argument, it was recognized that the Fifth Count could not stand since Overlook, not CGLIC, was the "administrator" of the "plan". See Tr. 2/26/79, p.54, l.19 to p.56, l.17.

terminated due to death, reaching the age of 65 or for other reasons.

In view of the disposition here that Lamb has no federal claim, and that there is no jurisdiction here over whatever State Law claims she may have, there is no need to deal with the class action aspect.[18]

As noted above, the attempt to state federal claims depends on the applicability of the Social Security Act, WPPDA or ERISA, or several of them.

The section of the Social Security Act relied on, 42 USC § 407, does not apply. That section does two things:

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[18] Lamb has no claim cognizable here, and so has no standing to represent some kind of class similarly situated. *Sosna v. Iowa*, 419 U.S. 393 (1975); *Kaufman v. Dreyfuss Fund*, 434 F.2d 727, at p.734 (CA 3, 1970), *cert. den.*, 407 U.S. 974 (1971).

Beyond that, Lamb has made no attempt to define a rational class. At argument, reference was made to data about all lines of CGLIC group policies, regardless of similarity or difference. See Tr., 2/26/79, p.7,1.16 to p.9,1.20. As shown by Appendix B, some States have regulated the subject, but most have not. Should the class be limited to New Jersey policies? Also, Lamb was an employee of an employer whose plan was not covered by WPPDA; should this be another parameter of the class? The master policy was terminated in early 1972; should this be another condition? These and other features make it unrealistic to think of a putative class as large as Lamb defines it. The implication is that Lamb wants to reach out and define a class not "similarly situated", but so broad as to convert a judicial proceeding to adjudicate a claim into something quite different and which it is the function of legislatures and administrative agencies to consider and deal with. The court notes that S.3017 was introduced in the Congress as the "ERISA Improvements Act of 1978", dealing expressly with employee *welfare* benefit plans and the matter of "frozen" versus "unfrozen" integration of disability "plans" with Social Security. The Congress has not passed the bill, and the court cannot be asked to do so in its stead. Even if it could, the change could not be retroactive.

1. It forbids assignment or transfer of "any future payments" under the subchapter;

2. It declares that none of the moneys paid or payable, or rights under the subchapter, are to be subject to execution, levy, attachment, garnishment, or other legal process or to the operation of any bankruptcy or insolvency law.

The policy terms here do not amount to an assignment or transfer of any future payments for social security benefits. The contract binds CGLIC to pay the difference between the benefits under the Social Security Act, payable "on account of" Lamb's disability, and 70% of her basic monthly earnings at disability, (i.e., $790 per month), with a guaranty of $50. per month in any event.

If the section forbidding assignment or offset applied at all, it would apply of necessity to the *entire* social security benefit, and not merely to *increases* from time to time, as alleged in the fourth count. It would completely bar any policy provision for integration with social security. Hence, so long as no law forbids the making of a contract to pay the difference between the social security benefits, whatever they may be, and some other larger number, or a minimum amount in any event, the social security law does not stand in the way. Such a contract, to pay something *more* than the Social Security benefit, can hardly be called a transfer or assignment merely because the amount to be paid will vary with the social security benefit level, subject always to the minimum.

Lamb ignores the fact that the tests for disability under the policy and under the social security law are different. Under the policy, if the participant is disabled so that he is completely prevented from performing the duties of his occupation or employment, benefits will be

paid for up to 24 months of continuous disability after the 6 month waiting period. This is not the test for disability benefits under social security. Under the Act, the term "disability" means

> "(A) inability to engage in *any substantial gainful activity* by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." 29 USC § 423(d)(1)(A). (Emphasis added)

Thus, an individual impaired from engaging in his usual occupation or employment, but capable of engaging in some other substantial gainful activity which can be performed in view of education and work experience, and for which jobs are available in the region, will be *ineligible* for any disability benefit under social security, but would be entitled to payment of full benefits, without deduction, under the CGLIC policy for 24 months after the waiting period.

After the 24 months of payments under the more generous test specified by the policy, the payments terminate unless the employee is so disabled that he is completely prevented from engaging in any occupation or employment for which he is qualified, or may reasonably become qualified, based on his training, education and experience. In that event the payments continue so long as the disability exists, up to age 65. Although worded differently, the policy test after the 24 month benefit period appears to be essentially the same as the social security test in underlying meaning.

The "freeze" provision in the Internal Revenue Code, and the regulations thereunder, 26 USC § 411(a) and 26 C.F.R. § 1.411(a)(4), discussed at greater length in Appendix A hereto, are addressed to the non-forfeitability

feature of *pension* plans and only affect their status as being "qualified" or not for income tax treatment. They are unrelated to "welfare" plans.

The second part of 42 USC § 407, above, is obviously not applicable since there is no kind of process to take away any part of the social security benefits. They reach Lamb in full and are in no way affected.

This disposes of any claims grounded on the Social Security Act.

The first discussion above shows that the Overlook plan was never covered by WPPDA because of Overlook's status under 26 USC § 501(c)(3), and the group policy involved was terminated in early 1972, so that ERISA has no application.

It is also quite clear that the attempt to allege that CGLIC was the "administrator" of a WPPDA plan has no foundation at all. The legislative history, as well as the language of the Act and the decisions, make it obvious that the "administrator" was Overlook, and that the benefits of the disability aspect of the welfare plan were merely provided by insurance issued by CGLIC. This being so, any request for information should have been addressed to Overlook, the employer/administrator rather than to CGLIC, and so the claim for $100 a day damages cannot stand. Beyond that, the request was in 1977 for a 1969 computer program, well beyond the 5 year retention period of WPPDA and the 6 year retention period of ERISA, aside from the misdirection of the request.

None of the facts being in dispute on these matters, CGLIC is entitled as a matter of law to summary judgment on all federal aspects of the amended complaint, and Lamb is not entitled to summary judgment on Count 3.

What remains, if anything, would be state law claims. The allegations of fraud, or of negligent misinformation, have no federal law foundation.

Having chosen erroneously to have labelled CGLIC as the "administrator", Lamb's original and amended complaints are mostly silent about Overlook, the actual administrator. Overlook's letter, at the front of Exh. A to the amended complaint, makes reference to what must have been both a welfare plan and a pension plan, although neither would be covered by WPPDA due to Overlook's status. The letter is addressed to "exempt" salary employees, a term clarified by other documents as referring to employees exempt from the Fair Labor Standards Act, 29 USC § 201, et seq. The exemption provision, 29 USC § 213(a) exempts (among others) any employee employed in a bona fide executive, administrative or professional capacity. In a hospital such as Overlook, Lamb (as a dietician) would be in this exempt class along with executive and administrative people and professionals such as staff nurses, salaried physicians and the like. The documents on discovery show that there were 93 of these in all in the group.

The letter goes on to refer to already existing features. One was composed of "pension and annuity programs". All the rest are benefits of a kind coming within the definition of a "welfare" benefit plan, as did the newly offered disability coverage.

Both WPPDA and ERISA contemplate that there be a "plan" which, in the context of the undisputed facts here, would have been an *Overlook* plan, of which the proposed disability coverage would have been an added feature. Discovery has produced no "plan" on the part of Overlook, nor any indication that any plan was "published", as called for by 29 USC § 307(a) or filed with the Secretary of Labor as required by 29 USC § 307(b). Had it been, it should have been found. Its non-

existence in any formal document is doubtless due to the fact that any such plan was not covered by WPPDA because of Overlook's status, and consequently inapplicable provisions were simply not complied with.[19]

Informal though Overlook's "plan" may have been, Lamb's complaint that the policy provisions involved were not fully explained in the advance brochure handed out by Overlook and discussed by its personnel is really a claim against Overlook, not against CGLIC. Nothing submitted even remotely suggests that the policy written by CGLIC was any different than had been requested by Overlook, acting as plan administrator on behalf of the group of exempt employees. Overlook would be an indispensable party to a suit asserting such a claim, and even if CGLIC were to be a proper party, the lack of diversity between Lamb and Overlook precludes jurisdiction in this court under 28 USC § 1332. Since all that remains undecided are potential state law claims against Overlook at least, and possibly against CGLIC, that remainder will be dismissed for lack of jurisdiction on the court's initiative pursuant to F.R.Civ.P. 12(h)(3).[20]

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[19] The Overlook application to CGLIC, Exh. p-17 of the Grosheider deposition, discloses that the Overlook "plan" at that time provided life and major medical benefits through a policy with Provident Life and Accident of Tennessee, and hospital and medical coverage through a group contract with Blue Cross/Blue Shield.

To take an example, suppose an employer announces a bonus plan to allow a salesman generating $X of sales to have the Cadillac of his choice from a local GM dealer. Suppose A qualifies, goes to the dealer, and is told that the employer only arranged to pay for a Buick. Can the salesman sue the dealer for a Cadillac, or is that claim one that can only be made against the employer?

[20] To summarize, the claim that the Social Security law itself bars the offset or full integration of the benefits payable to the claimant and dependents "on account of" the claimant's disability is simply unsupported. *Hurd v. Illinois*, 136 F.Supp. 125 (D.Ill., 1955), *aff'd.*, 234 F.2d 942 (CA7, 1956), *cert. denied* as *Seybold v. Western Electric*, 352 US 918 (1956), *reh. den.*, 352 US 942

The state law nature of remaining claims is underscored by the fact that some states have, by statute or regulation, dealt with the subject of integration and offset as a matter of their authority to specify what provisions may or may not be included in one or another kind of policy issued in each state. This is a recognized function of the states and involves local law, not federal law. A list of the references located by the court is attached as Appendix B, and it discloses that New Jersey has not placed any restriction on integration provisions in insurance policies.

/s/ Vincent P. Biunno,
U.S.D.J.

March 3, 1980

Original to Clerk
xc: Robert H. Jaffe, Esq.
Eugene M. Haring, Esq.

(1957) deals with the point directly since neither WPPDA nor ERISA existed at that time. The situation here is the same because neither Act applies to this case. As the trial court observed in *Hurd*, the legislative history shows that the Social Security law was not intended to bar offset against amounts payable under private arrangements, see 136 F.Supp. at 142-144. See, also, *Dowell v. Aetna, etc.*, 468 F.2d 802 (CA 4, 1972).

Coughlin v. CGLIC, 330 A.2d 159 (Del Super.1974) is plaintiff's main support for the claim that the dependents' benefits cannot be taken into the calculation. However, that case turned on a construction of the contract according to State law, and not on federal law. The reference to 42 USC 402(d)(1) was solely for the purpose of supporting the construction of the policy, and not to suggest that it barred offset or integration for dependents' benefits. In fact, the Delaware court refers to *Dowell*, but distinguishes it on the ground that the language and construction were different.

Cases in the category of *Philpott v. Essex, etc. Board*, 409 U.S. 413 (1973) do not apply because they involve the use of some kind of "process" to enforce a claim against the social security benefits

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themselves. These cases do not involve the situation here, which is concerned with a formula in which specified collateral source benefits are a variable used to decide how much should be paid under the policy *in addition to* the collateral source benefits. But see *Western Electric v. Traphagen*, 166 N.J. Super. 418 (App. 1979), an ERISA case, where garnishment of a former husband's pension was allowed to satisfy an alimony obligation.

Hisquie[r]do v. Hisquie[r]do, —— U.S. ——, 59 L. Ed. 2d 1 (1979) does not apply. The question there was whether a husband's inchoate interest or expectation to possible pension benefits under the Railroad Retirement Act (and which he would enjoy if he lived to retirement) could be taken into account under California's community property law. It was in this connection that the court observed that the potential benefits, like those under Social Security, are not contractual and that the Congress can go so far as to repeal the entire Act.

Nor does it make any difference, as the court sees it, that Overlook paid 25% of the premium and participants paid 75%[.] CGLIC contracted for a single premium, and whether one or the other paid it all, or whether it was divided, was a matter between them to resolve. In fact, since Overlook is a § 501(c)(3) organization, it presumably files no income tax return and receives no deduction for its share of the premium as a profit-making employer would.

Clearest of all, however, is that Lamb's dealing was only with Overlook. If Overlook bought a contract that provided less than it undertook to do under its "plan", Lamb's real state claims are claims against Overlook, not CGLIC, and she cannot sue Overlook in this court on state claims.

See, too, *Jaffess v. HEW*, 393 F. Supp. 626 (D.N.Y., 1975) where a war veteran entitled to a non-service connected disability pension under 38 USC § 521 was obliged to report to the VA the fact and amount of a Social Security award for disability benefits so that they would be offset with the military pension. The collateral sources so integrated are very broad, and where the pensioner is married and has children, their collateral sources are included. See 38 USC § 503.

APPENDIX A

HISTORY OF EMPLOYEE WELFARE AND PENSION PLANS

The now widely used employee welfare and pension benefit plans, supplemented by self-employed (Keogh) retirement plans and individual retirement accounts (IRAs) have an interesting general history which it has been necessary to explore in connection with this case, and which provides context and meaning to the analysis for the rulings made.

Before World War II, there was no general or widespread pattern for any kind of private plan. With the wage and price controls in force during the War, the practice developed of negotiating for deferred compensation through the medium of one or another kind of pension or retirement plan. It must be remembered that during the war period, income tax rates ran as high as 90%, and there was hardly an industry that was not heavily engaged in defense production under government contracts commonly on the basis of "cost-plus". Since the fringe benefit expense for an employee plan was recognized as cost, the combination of circumstances made it quite natural, and in the common interest of both employers and employees, to establish welfare and pension plan arrangements as fringe benefits in lieu of wage increases, which were severely limited by law.

This general background is referred to in Senate Report No. 1440, to accompany S.2888, and in House Report No. 2283, to accompany H.R. 13507, which, after Conference Report No. 2656, to accompany S.2888, eventually became the Welfare and Pension Plan Disclosure Act of 1958 (WPPDA), 29 USC § 301, et seq., now repealed.

Similar historical background is also found in the extensive committee and conference reports in connection

with the enactment of the Employee Retirement Income Security Act of 1974 (ERISA), 29 USC § 1001, et seq., plus various sections of 5 USC, 26 USC, and 42 USC.

The development of various plans as fringe benefits during the war years had been preceded by two programs, one public and one private, which had originated during the Depression years. The public program was the Social Security Act, 42 USC, which began as a system to provide old age benefits after retirement, although its scope has since been broadened in a number of ways. The private program was the Blue Cross hospital service plan, later enlarged to include surgical benefits through the related Blue Shield program, and a degree of non-surgical medical service through Rider J.

The Social Security old-age retirement plan was structured essentially like a pension plan, with contributions (in the form of Social Security taxes) assessed equally between the employer and the employee. Unemployment compensation plans, structured somewhat along the lines of Social Security were also developed, and later on long-term disability benefits were added to the Social Security program, as well as supplemental income benfits later on measured on a "needs" basis.

Except for the supplemental income program, the format of Social Security benefits (whether for old age retirement or disability) was such that the level of benefits was related to formulas (sometimes complex) based on the level of taxable earnings and duration of employment as a covered worker, but without regard to the assets or investment income of the beneficiary. The same was true of Blue Cross/Blue Shield, except that since these were "service" plans dependent on the willingness of participating hospitals and physicians to render specified services at rates and fees set by the Plans, there has always been a partial means test in that if the subscriber's earnings exceeded a specified

level, a higher rate or fee could be charged, with the Plan paying the specified sum and the subscriber being responsible for the difference.

From the start, all of these programs carried with them some number of tax consequences under the Internal Revenue Code. Thus, the Social Security contribution levied on the employer is an allowable deduction to the employer as a business expense under I.R.C. § 162. The same is true of payments made by an employer as part of or all the cost of hospital, medical or other welfare protection for employees. And, on the other side of the tax implications, the contributions of an employer to accident and health plans for compensation (through insurance or otherwise) to his employees for personal injuries or sickness (whether work related or not), are excluded from the gross income of the employee, 26 USC § 106.

In the case of pension plans, as distinguished from welfare plans, a wide variety of systems developed over the years. In a sense the simplest plan was a plan by which the employer undertook by contract to pay a stated amount per period after retirement, the amount being measured by years of service and level of compensation, or some such formula. These simple plans were not funded in any way. Instead, when an employee retired the employer merely made payments periodically as agreed, out of current revenues. Another form consisted of plans for which the employer made installment payments during employment toward the purchase of an annuity contract which, at retirement, would have accumulated a value sufficient to satisfy the periodic retirement payments. Another form was to establish a trust, either with a financial institution as trustee, or with labor and management representatives as trustees. The latter form was (and probably still is) the most common for multi-employer plans in the construction trades, where

employees commonly do work for a variety of employers to whom he is assigned by the construction trades union to which he belongs. To a lesser degree, some plans were based on profit sharing, stock options, and the like. No doubt there are other varieties.

The earliest kind of federal legislation dealing with any kind of plan consisted of provisions of the Internal Revenue Code, and of these the earliest that dealt with plans in a specific and comprehensive way are found in the 1954 Code, 26 USC § 401 et seq., establishing the concept of "qualified" pension plans. The term "qualified" is a shorthand adjective for a variety of consequences under the Internal Revenue Code. The initial objective, as enacted in 1954, was to deny the tax benefits of having a "qualified" status if the terms of the plan "discriminated in favor of employees who are officers, shareholders or highly compensated, and if it were possible, under the terms of the plan, to divert the corpus or income to purposes other than for the benefit of the employees or other beneficiaries before all liabilities to them had been fully satisfied. This key section, 26 USC § 401, has been amended a number of times and today presents a formidable text. See Pub. L. 87-792, § 2 (Oct. 10, 1962); Pub. L. 87-863, § 2(a), (Oct. 23, 1962); Pub. L. 88-272, § 219(a) (Feb. 26, 1974); Pub. L. 89-97, § 106(d) (July 30, 1965); Pub. L. 89-809 §§ 204(b)(1), 204(c)[,] 205(a) (Nov. 13, 1966); Pub. L. 91-691, § 1(a) (Jan. 12, 1971); Pub. L. 93-406, §§ 1012(b), 1016(a)(2), 1021, 1022(a) to (d), 1022(f), 1023, 2001(c) to (e)(4), 2001(h)(1), 2004(a)(1) (Sept. 2, 1974); Pub. L. 94-267, § 1 (c)(1) and (2) (Apr. 15, 1976); Pub. L. 94-455, §§ 803(b)(2), 1505(b), 1901(a)(56), 1906(b)(13)(A) (Oct. 4, 1976); Pub. L. 95-600, §§ 135(a), 141(f)(3), 143(a)[,] 152(a) (Nov. 6, 1978). Yet, the above themes predominate even today despite sophisticated refinements and added coverage to deal with plans

for self-employed individuals, owner/employees and the like.

What is significant about these sections of the Internal Revenue Code, 26 USC § 401, et seq., is that they deal with pension plans for retirement benefits, and not with welfare plans as defined either by WPPDA or ERISA. There seems to be but one provision, § 401(h) which mentions benefits for sickness, accident, hospitalization, and medical expenses, which are among the recognized purposes of welfare benefit plans rather than pension benefit plans. However, this provision does no more than state that the inclusion of such benefits to *retired* employees, spouses and dependents will not prevent the plan from being "qualified" as a pension plan so long as (1) the benefits are subordinate to the retirement benefits; (2) a separate account is established for such benefits; (3) the employer contributions to the separate account are reasonable and ascertainable; (4) the corpus or income of the separate account cannot be diverted to any purpose other than to provide those benefits; and (5) when all liabilities for the benefits have been satisfied, any balance in the separate account must be returned to the employer.

Thus, 26 USC § 401(h) clearly does not deal with a "welfare plan" as defined by both WPPDA and ERISA.

WPPDA of 1958 was evidently the first federal statute purporting to deal with welfare and pension plans, and it dealt with them only in the relationship of employer/employee. The WPPDA text itself, as well as the explicit statements in the committee reports are clear that the Act made no attempt to regulate welfare or pension plans in any way, and dealt only with employee oriented plans to the extent of establishing a mechanism for reporting and disclosure. This is confirmed by the

Supreme Court ruling in *Malone v. White Motor Corp.*, 435 U.S. 497 (1978).

The committee reports on WPPDA made clear that the Congress was aware of the indirect regulation already afforded by the Internal Revenue Code, and the final bill omitted any provisions for criminal penalties, on the theory that 18 USC § 1001 provided adequate coverage. See next to last paragraph of Conference Report No. 2656, Aug. 15, 1958, to accompany S. 2888.

Four years later, Pub. L. 87-420, § 17(e) (March 20, 1962), enacted what is now codified as 18 USC § 1954 to make criminal the offer, solicitation or acceptance of any thing of value because of, or to influence, any action, decision or other duty in connection with an employee welfare or pension benefit plan as defined by WPPDA (since amended to refer to the definitions of ERISA).

The history of ERISA is extensive and bulky. The Act as passed was the distillation of many bills, as reflected in the committee and conference reports mentioned above, and it shows that, unlike WPPDA, the object of ERISA was mainly regulatory, and the focus was centered on pension plans rather than welfare plans. As introduced and discussed, the bill would have merely amended and supplemented WPPDA, as to welfare plans, and the rest dealt with problems unique to pensions. These features deal with funding, eligibility and vesting, non-forfeitability, fiduciary responsibility, prohibited transactions, and the like. One important feature, not included in the Act as passed, dealt with portability and would have established a centrally administered fund through which accrued and vested shares in one plan could be exchanged for an equivalent or superior share in another plan when changing jobs. Provision was included for insurance, like FDIC and SIPC, in case of the financial failure of a plan, but only for pension plans, not for welfare plans.

In the end, WPPDA was not amended and supplemented, but was repealed. Administrative aspects were divided between the Department of Labor and the Treasury Department. The general provisions, as well as those dealing with reporting and disclosure, fiduciary responsibility and administration and enforcement, apply to both welfare and pension plans. The parts dealing with participation and vesting do not apply to employee welfare benefit plans by express language of § 201 and § 301. The amendments to the Internal Revenue Code, by the addition to Title 26 of §§ 410-415 deal only with pension plans and not with welfare plans. The same is true of the amendments to 26 USC § 401, and by the addition of 26 USC §§ 6057, 6058 and 6059. The addition of § 1131 to 42 USC, imposing duties on the Secretary of HEW deals only with pension plans, and not with welfare plans. The addition of 7676 to Title 26, to authorize declaratory judgments in the Tax Court, is limited to retirement plans in the form of (1) a pension, profit-sharing, or stock bonus plan; (2) an annuity plan described by § 403(a), and (3) a bond purchase plan described in § 405(a). All are pension plans; none is a welfare plan.

The provisions in respect to the Pension Benefit Guaranty Corporation (ERISA §§ 4001-4068), also apply only to pension plans and not to welfare plans.

Other criminal statutes which had been enacted by supplement to WPPDA, such as 18 USC § 664 (embezzlement or conversion from employee benefit funds) and 18 USC § 1027 (making any knowingly false statement in any document required by the Act), were amended to substitute references to ERISA rather than to WPPDA, and apply to both welfare and pension plans, as does 18 USC § 1954 (kickbacks).

These criminal statutes roughly parallel analogous statutes dealing with federally insured banks, such as

18 USC § 656 (embezzlement or misapplication by a bank officer) [;] 18 USC § 1005 (false entries in bank records); 18 USC § 1014 (false statements in loan applications) and 18 USC § 215 (kickbacks on loans, etc.).

From this history and analysis, it is plain that from the entire universe of welfare and retirement plans, the Congress has chosen to legislate to encourage some of them by favorable tax treatment in the Internal Revenue Code, and, in the case of those employee oriented plans covered by WPPDA, acted between 1958 and 1975 to require certain reporting and disclosure but did not regulate, and since 1975, by ERISA, has undertaken to regulate, such plans to the extent that they are pension plans.

Except as included in one or another of these federal statutes, the Congress has not enacted any law dealing with other kinds of plans in the universe of plans, whether constructed on an individual basis or by groups other than those composed of employees of an employer or groups of employers or of employees.

Natural persons thus remain free of federal law of this kind to establish individual, family and group plans or programs to deal with all the countless risks that life in a complex society entails. They may design all manner of savings plans, from the simple bank account at interest on through term certificates, T-bill certificates, on to sophisticated investment portfolios of debt and equity securities. They may invest in land or other property. They may buy insurance of all kinds, whether of an indemnity or investment nature, including protection against the risks of fire, lightning and extended coverage risks; burglary, theft and mysterious disappearance; homeowners' and automobile or water vessel or aircraft liability; hospital and medical expense policies, including major medical and disability benefits whether caused by accident or sickness; life insurance in all its

variations, from term to endowment; and annuities. This list does not exhaust all the available choices freely available on a voluntary basis, which may play a part in establishing individual or group programs for providing security against risks.

Yet, except in peripheral ways, such as through the SEC, and through regulating interest rates and terms of various kinds of deposits in banking institutions, federal law does not attempt any direct regulation of that part of the field. So much as has been dealt with, mainly in the Internal Revenue Code, WPPDA and ERISA, has been confined to matters of special tax treatment, to reporting and disclosure, and to rather strict regulation of plans that are employer/employee oriented, except for the very recent developments, mostly with tax consequences, of HR-10 or Keogh Plans and IRA's in an effort to provide means to those outside the traditional labor/management sphere to achieve some measure of equal tax treatment in respect to pensions and retirement.

So far as the regulation goes, its major aim is to establish minimum standards for eligibility and vesting, and to require suitable funding to minimize the risk that there will be insufficient funds to provide the benefits specified by the plan. By and large the Congress has not made the establishment of any plan mandatory, nor has it attempted to specify what the particular benefits are to be.

Thus, there is nothing illegal or forbidden about establishing a plan that would otherwise fall within ERISA, for example, but that fails to qualify with its requirements. The only consequence of such a course of action is that by failing to qualify, the tax benefits otherwise available will be denied. If someone wishes to follow that course he is free to do so. ERISA itself makes it explicit that the participation and funding provisions

of an employee pension benefit plan, 29 USC § 1051 through 1061, do not cover (among others)

. . . an unfunded plan maintained by an employer primarily to provide deferred compensation for a select group of management or highly compensated employees (29 USC § 1051(2));

. . . a plan of a labor organization described in 26 USC § 501(c)(5) which has no provision for employer contributions after September 2, 1974 (29 USC § 1501(4));

. . . agreements for payments to a retired partner or a deceased partner's successor in interest (i.e., a widow) under 26 USC § 736 (29 USC § 1051(5));

. . . an excess benefit plan, which is one providing benefits in excess of the limitations specified by 26 USC § 415 for a "qualified" plan (29 USC § 1015(7)).

For these, and for all other plans not directly regulated by federal law, the party involved is free to "write his own ticket", subject only to compliance with applicable State law, and with the consequence that one or another tax benefit will not be available.

Insofar as one or another plan may involve the use of an insurance policy, it must be kept in mind that for most of the history of insurance systems in this country, the law was that it did not constitute commerce and was not within the reach of Congress. See *Paul v. Virginia*, 8 Wall. 168, 19 L. Ed. 357 (1869). It was not until 75 years later, in *U.S. v. Southeastern Underwriter Ass'n*, 322 U.S. 533, 88 L. Ed. 1440 (1944), that the Supreme Court, by a vote of 4 to 3, explained *Paul v. Virginia* as focused on the validity of state statutes, and not on the issue, not squarely presented before, whether the Sherman Anti-Trust Act was intended to and could

apply to interstate insurance. The Court ruled that it did. See, also, *Polish Alliance v. NLRB*, 322 U.S. 643, 88 L. Ed. 1509 (1944), decided the same day.

Early in 1945, Congress passed the McCarran Act, Pub. Law 15, which affirmatively consented to the continued regulation of insurance by the states and suspended the application to the insurance business of the Sherman Act, the Clayton Act, the Federal Trade Commission Act, and the Robinson-Patman Act. After the suspension period, those acts were to apply to the insurance business only to the extent that it was not regulated by state law. See, 15 USC § 1011 to 1015.

Neither in the Internal Revenue Code provisions applicable here, nor in WPPDA, nor in ERISA, did the Congress undertake to regulate the business of insurance in any way. To the extent that insurance is mentioned, it is either by way of recognition that one or another form of insurance had long been, and could continue to be, used as the medium to provide the benefits specified by a particular plan (including annuities where applicable to pensions), and that where information to be reported and disclosed by a plan administrator was not in the administrator's hands and could only be supplied by the insurer, it was required to supply it to the administrator of the plan on the administrator's request. This is as far as WPPDA went while it was in force, in respect to plans to which it applied. ERISA goes somewhat further in cases where a "separate account" is required.

Insofar as the subject involved here is concerned, i.e., the offset or integration of social security, workers compensation, and the like, the Congress has recognized that plans in existence contained such offset or integration provisions, both "frozen" and "unfrozen". The subject is discussed in the committee reports on ERISA.

Conference Report No. 92-1280 discusses integration with social security in connection with pension plans and says that under Titles I and II of the conference substitute, plans may not decrease benefits due to increases in social security benefit levels "in the case of retirees, or [vested] individuals who separate from service before retirement". It also called for a study by the Congress over a two-year period, "of the issues involved in the integration of *private pension* plans with social security". [emphasis added]

As observed in *Buczynski v. General Motors*, —— F.2d —— (CA 3, #79-1668, 2/15/80), the offset or integration subject was not dealt with explicitly in ERISA as enacted, although embraced by the general prohibition against forfeiture in 29 USC § 1053(a). What occurred was that the subject was eventually addressed by a Treasury Regulation found at 26 CFR § 1.411(a)(4), under the authority of the antiforfeiture provision in the ERISA amendment to 26 USC § 411. The Treasury Regulation declares that offsets are not prohibited forfeitures, although as to social security offsets, it employs a "frozen" formula rather than an unfrozen formula, from September 2, 1974.

The Internal Revenue Code provisions of ERISA, as observed above, are limited in their application to the question whether *pension* plans are "qualified" or not for tax purposes. They do not apply to welfare plans at all, they do not apply to group insurance policies for long-term disability which were terminated more than two years before ERISA was enacted, and they certainly do not purport to change the terms of such a contract so as to increase the obligation of the carrier beyond the explicit provisions of the terminated policy.

Even if there was a pension plan involved, rather than a disability policy to satisfy a welfare plan, and even if through some oversight the employer purchased an

annuity contract calling for full integration with social security when 26 USC § 411 limited integration to a modified frozen offset, the consequences would be that (a) the plan would not be "qualified" for tax purposes and (b) the employee might have a claim against the *employer* for the difference in benefits as the result of buying the wrong kind of annuity contract. Nothing in the federal statutes would support a federal claim by the employee against the carrier that wrote the annuity contract to compel the carrier to pay more than its contract called for.

Government pension plans, both federal and state, are excluded from both WPPDA and ERISA. If government plans have any single characteristic, it is that they either are unfunded or inadequately funded. There is a strong tendency, whenever there is a current surplus (in contrast to an actuarially determined fund surplus) to broaden risk coverage and to increase benefit amounts. The federal government, in connection with social security benefits, is perhaps the worst offender in this regard. The so-called "trust funds" are currently projected to run short of benefit needs within several years. Controversy rages about putting on some sticking plaster by lending money from one fund to another, whether to reduce benefits, whether to increase the social security tax, or whether to draw on general tax revenues from deficit budgets to make up the shortage.

New York City seems to be another major offender. According to press reports when it was on the brink of bankruptcy, it was said that benefit levels were set according to earnings of the highest of some number of recent years, including overtime, and that prospective pensioners with enough seniority to demand it were putting in all the overtime they could in the year before retirement. Not only that, but it was also said that the actuarial assumptions currently used to estimate the

proportion of city employees likely to retire at various ages was based on experience data of about 1916, in the face of current knowledge that early retirements are now far higher than they were then.

If government, which has unlimited taxing power, wishes to broaden coverages and increase benefits far beyond what the contributions to the trust funds will support, it is within its power to do so, whether wise or not. But there is simply no way in which government can compel privately contracted payments to be increased beyond the level agreed to without threatening the very feature that the pension aspects of ERISA were intended to protect, namely the financial soundness and ability to pay the benefits agreed to. Private enterprise does not have the power to tax. It cannot make up the difference.

Order Filed March 5, 1980

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

Civil 77-1290

ANNELIESE B. LAMB,
Plaintiff,

vs.

CONNECTICUT GENERAL LIFE INSURANCE CO.,
Defendant.

ORDER FOR SUMMARY JUDGMENT

For the reasons set out in the opinion of even date, it is on this 3rd day of March 1980 ORDERED that:

1. Plaintiff's motion for summary judgment on Count Three is denied.

2. Defendant's motion for summary judgment in its favor is granted in respect to all federally based claims, and judgment thereon will be entered in its favor and against plaintiff.

3. The remainder of the amended complaint is ordered dismissed for lack of jurisdiction in this court, pursuant to F.R.Civ.P. 12(h)(3).

/s/ Vincent P. Biunno
U.S.D.J.

Original to Clerk
xc: Robert H. Jaffe, Esq.
Eugene M. Haring, Esq.

ATTACHMENT TO NOTICE OF APPEAL

Order Granting Summary Judgment And Granting Plaintiffs Leave To File Amended Complaint Filed July 31, 1978

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

THE HONORABLE VINCENT P. BIUNNO

Civil Action No. 77-1290

ANNELIESE B. LAMB, individually and on behalf of all other persons similarly situated,
Plaintiff,

vs.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY, a corporation of the State of Connecticut,
Defendant.

ORDER GRANTING SUMMARY JUDGMENT
WITH LEAVE TO FILE
AMENDED COMPLAINT

This matter being opened to the Court by McCarter & English, Esqs., attorneys for defendant, Eugene M. Haring, Esq., appearing, seeking an Order for Summary Judgment pursuant to Rule 56; in the presence of Robert H. Jaffe, P.A.[,] attorneys for plaintiff, Robert H. Jaffe, Esq., appearing; the Court having considered the affidavits and briefs in support of and in opposition to the motion and having considered the arguments of counsel at hearings held on March 30, 1978, and June 12, 1978; it appearing to the Court that there is no genuine issue as to any material fact, that there is no ambiguity in the policy language at issue, and that defendant is entitled to judgment as a matter of law on all the issues raised by the Complaint herein; and it further appearing

from the representations of counsel at the hearing on June 12, 1978, that plaintiff may seek to file an amended Complaint; and good cause appearing;

IT IS on this 31st day of July, 1978;

ORDERED, ADJUDGED, AND DECREED that the defendant's motion for summary judgment is hereby granted and the Complaint herein is dismissed with prejudice and without costs;

IT IS FURTHER ORDERED that plaintiff is granted leave to serve and file an amended Complaint within ten (10) business days from the date of the entry of this Order, jurisdiction is retained for trial purposes and any ensuing proceedings.

/s/ Vincent P. Biunno
VINCENT P. BIUNNO
U.S.D.J.

Hearings On Defendant's Motion For Summary Judgment Dated June 12, 1978 Filed October 16, 1978

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

Civil No. 77-1290

ANNELIESE B. LAMB,
Plaintiff,

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY,
Defendant.

Newark, New Jersey
June 12, 1978

TRANSCRIPT OF PROCEEDINGS

BEFORE:

THE HONORABLE VINCENT P. BIUNNO, U.S.D.J.

Appearances:

ROBERT H. JAFFE, ESQ.,
Attorney for Plaintiff

McCARTER & ENGLISH, ESQS.,
By: EUGENE W. HARING, ESQ.,

and

RICHARD M. EITTREIM, ESQ.,

and

STEPHEN G. SIEGEL, ESQ.,

Attorneys for Defendant

* * * *

[2] THE COURT: All right, Lamb against Connecticut General.

I've read the papers. There is no point in talking about an amended complaint which hasn't been filed yet and which needs leave to be filed because I don't have it before me. In any event, the plaintiff should be aware that if the plaintiff's motion—the defendant's motion is granted, there is any indication that the plaintiff feels capable of filing a complaint that is valid against the motion, leave would be granted in any event to file such a complaint within a reasonable time to be stated. But so far as the argument of this motion is concerned, the fact that you're contemplating an amended complaint is not a matter to be considered. It doesn't address the motion.

MR. JAFFE: I understand, your Honor. I hope to have the papers there which in some ways could be referred to, but I agree with the Court that—

THE COURT: Well, that's something else.

MR. JAFFE: All right.

THE COURT: Now, frankly, I don't see the basis for any claim under the present complaint. I don't know what other complaint you're going to have. We'll face that when, as and if it's filed. But on the present complaint, it seems to me that what you have gotten and gathered discloses what everybody knows anyway, namely that when you [3] buy a disability plan or any other kind of dollar payment plan on a group basis, whether for employees or not, you can buy them through the Bar Association to, you know, for example, by your own. You can either get fixed dollar amount, so much a week, so much a month, what have you, or a formula that amounts to the same thing.

Or you can get payments which is set at a given level, and which will remain there when combined with other benefits available from other sources. So that the

benefits under the policy and the benefits from other sources combined will equal a given number. That costs less. It costs less because some number of the people in the group will not get the other benefits and some will. So that the total dollars paid out will be somewhat less than a full dollar—fixed dollar system would cost.

The third variation, we are speaking now particularly of things like social security, either retirement type or disability type. The full benefits received from the other sources are taken into account in determining how much is to be paid under the policy so that the total received under the policy and under the other benefits will equal the fixed sum which the policy underwrites.

Here you have the variation, the social security benefits, at least since the 50's, have been periodically increased for existing beneficiaries. As social security [4] increases, it benefits the amount payable by the insured, would be reduced to that extent. So the total would remain the same.

That form of coverage costs still less for the obivous reason that the exposure is reduced to some extent. Arriving at the premium is an actuarial process. It isn't precisely any more than any other actuarial calculations. Those calculations are at their most reliable when you're dealing with straight life insurance.

The experience under the mortality tables is highly reliable. The experience on disability is less forecastable. The smaller the group the more uncertainty is introduced into the estimated actuarally.

On some group contracts the company that underwrites it may lose its shirt. On other ones it may make a profit. There is no way of knowing in advance which it will be.

From the papers that have been submitted, it seems entirely clear that there is no question that what the employer negotiated for here to offer to its employees, who I take it were non-union, am I right on that?

MR. HARING: I believe you are.

THE COURT: They had no collective bargaining agent.

MR. HARING: No, your Honor.

[5] THE COURT: Something offered by the employer. Was a disability group plan designed to pay a fixed dollar amount based on a percent of salary? So that's a formula which becomes ascertainable when the claim ripens.

It calls for offset of the benefits, including social security disability benefits of all kinds.

It is argued that the language in the policy, the language in the booklet, the language in the summary sheet, that sort of thing, doesn't spell out all these details. I don't think that is a valid point. I think it misconstrues the meaning of what's there.

What is there says there is a deduction for other benefits. It follows if the other benefits fluctuate, then the amount payable under the policy will fluctuate. It would only be necessary and be more explicit if the deduction for other benefits were to be other than for the amount of the other benefits, namely some lesser amount, a so-called frozen method. That would need to be spelled out.

To give an example of why this language is perfectly adequate and entirely clear on this point, consider the fact that one of the elements in the offset is benefits payable by social security for dependent minor children. Dependent minor children either reach majority or cease to be dependent or die, or one way or another at some point no longer form a basis for a payment. When, as and if that [6] happens, the payment from social security becomes smaller. The payment from the company would become larger. Neither the policy nor the booklet nor the summary statement says so, but what is there obviously leads to that result without any dispute about it and without any need for construction.

It seems to me that the present motion should be granted and an order to that effect should be entered. It should grant leave to file an amended—to serve and file an amended complaint. Is ten business days enough?

MR. JAFFE: From the date of the order, your Honor?

THE COURT: Yes.

MR. JAFFE: Yes.

THE COURT: Within ten business days from the date of the order. I've been using that lately so you don't have to figure whether the last day falls on a Saturday, Sunday or holiday. Anything else?

MR. JAFFE: Your Honor has ruled. I'll have a chance in my amended complaint. I will reserve my argument which undoubtedly will come up again at that point.

THE COURT: Thank you.

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 80-1523

LAMB, ANNELIESE, B., individually and on behalf of all other persons similarly situated

vs.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY, a Corporation of the State of Connecticut

ANNELIESE B. LAMB,
Appellant

(D.C. Civil No. 77-1290)

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEW JERSEY

Present: ADAMS, GARTH and SLOVITER, *Circuit Judges*

JUDGMENT

This cause came on to be heard on the record from the United States District Court for the District of New Jersey and was argued by counsel on December 4, 1980.

On consideration whereof, it is now here ordered and adjudged by this Court that the judgment of the said District Court, entered March 5, 1980, be, and the same is hereby affirmed. Costs taxed against appellant.

ATTEST:

/s/ Sally Jarvos
Clerk

February 23, 1981

APPENDIX D

Affidavit Of Robert H. Jaffe, Esq. Filed March 23, 1978

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW JERSEY

HONORABLE VINCENT P. BIUNNO

Civil Action No. 77-1290

ANNELIESE B. LAMB, individually, and on behalf of all other persons similarly situated,
Plaintiff,

vs.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY, a corporation of the State of Connecticut,
Defendant.

AFFIDAVIT OF COUNSEL FOR PLAINTIFF PURSUANT TO RULE 56(f) IN OPPOSITION TO MOTION FOR SUMMARY JUDGMENT

STATE OF NEW JERSEY)
) ss.
COUNTY OF UNION)

ROBERT H. JAFFE, of full age, being duly sworn according to law, upon his oath, deposes and says:

1. I am an attorney at law of the State of New Jersey and a member of the law firm of Robert H. Jaffe, P.A., attorneys for plaintiff Anneliese B. Lamb ("Lamb"). I make this affidavit pursuant to Rule 56(f) of the Federal Rules of Civil Procedure and other applicable rules of this Court in opposition to the motion for summary judg-

ment sought by defendant Connecticut General Life Insurance Company ("CGLIC").

2. At the heart of the complaint in this class action is whether defendant CGLIC is entitled to decrease monthly benefits paid to plaintiff Lamb and other permanently disabled persons similarly situated under a standard group long term disability insurance policy sold through employers by an amount equal to increases in government disability payments under the Social Security Act mandated by the United States Congress since 1972, in order to offset and compensate for increases in cost of living factors in accordance with a formula established by federal statute. The type of standard group disability insurance policy at issue in this action is one whereby the employee pays approximately three-quarters of the premium and the employer pays approximately one-quarter of the premiums.

3. One of the most important questions to be determined in this class action is what were the factual circumstances surrounding the sale by defendant CGLIC of its standard group long term disability insurance policies to employers of persons such as plaintiff Lamb. The reconstruction of these factual circumstances include such factors as the actuarial basis for the premium initially charged, the actuarial basis or calculations for any increase in premium, copies of any and all communications, including, but not limited to, booklets, notices and advertisements sent to the employer of plaintiff Lamb and/or other interested parties to the sale of the group policy at issue, when originally sold by defendant CGLIC and the first premium paid, copies of all communications sent to plaintiff Lamb and all other employees eligible for coverage under the group long term disability insurance policy sold to Overlook Hospital explaining the basis for the initial and any increased premium rates etc.

4. Information relating to the above enumerated factual matters have been requested by way of interrogatories served on defendant CGLIC in August, 1977 and requests for document discovery served on counsel for defendant CGLIC in January, 1978.

5. The requests for information as to the basis for premium rates made in the interrogatories were not adequately responded to and resulted in a motion to compel discovery which was denied by this Court in February, 1978 without prejudice to renewal after this motion for summary judgment was heard.

6. There has been no response by defendant CGLIC to a request for document discovery to be supplied on March 2, 1978 at the offices of counsel for the plaintiff pursuant to the Plaintiff's First Request To Produce Documents, a copy of which is attached to this affidavit as Exhibit "A". Said request for document discovery would have supplied information pertinent to the factual circumstances under which plaintiff Lamb purchased coverage through her employer Overlook Hospital of Summit, New Jersey under the standard group long term disability policy sold by defendant CGLIC.

7. The importance to plaintiff in obtaining the discovery requested and refused by defendant CGLIC is highlighted by the statement made in the affidavit of Lawrence A. Jenson, Secretary of Group Insurance Operations of defendant CGLIC, that:

> "(A)t the time Overlook Hospital purchased the policy in question (defendant CGLIC) also offered a so-called 'frozen' Social Security integration provision. Under this 'frozen' provision, the offset for Social Security benefits was permanently fixed throughout the period of disability as the amount of Social Security benefits received by the insured at the time disability payments commenced under the

policy. Overlook Hospital chose the 'unfrozen' integration provision and paid a lower premium than would have been required if the 'frozen' integration provision had been purchased."

8. The affidavit of Mr. Jensen was signed on March 2, 1978 the same day that document discovery was requested of defendant CGLIC but was not forthcoming. There is not one document attached to the affidavit which corroborates the factual assertions made therein. Further, his affidavit was not filed until March 8, 1978 more than three weeks after the Notice of Motion for Summary Judgment had been served on counsel for plaintiff Lamb. Although a request for deposition of Mr. Jenson has this week been filed on defendant CGLIC, it will be impossible to depose him with respect to the factual assertions made in his affidavit prior to the hearing in the instant motion for summary judgment now scheduled to be heard on Thursday, March 30, 1978.

9. The factual assertions set forth in the affidavit of Mr. Jenson appear to contradict the admittedly incomplete answers of defendant CGLIC to interrogatories of the plaintiff. The very first interrogatory was as follows:

"With regard to the premiums paid by plaintiff Lamb for her group disability policy with Overlook Hospital Association, state how defendant CGLIC arrived at the basis for the initial premium rate of $1.14 for $100 of Monthly Benefit."

The answer to this interrogatory, certified to by Leonard A. Mytych, Director of Long Term Disability Claims, Group Insurance Operations of defendant CGLIC and mailed counsel for plaintiff Lamb on or about December 2, 1977 states that the monthly premium which totals $1.48 (of which plaintiff Lamb paid $1.14)

"was calculated in accordance with a computer program developed for that purpose *which is no longer*

in existence. The program was based on four factors: 1) frequency of disability occurences based on 1964 Commissioner's Disability Table (CDT), 2) termination rate based on 1964 CDT, 3) loading factors, and 4) *Social Security integration calculation based on either unfrozen or frozen Social Security integration.*" (Emphasis added.)

10. There is an evident contradiction in the answer given by Director Mytych to the first interrogatory indicating plaintiff Lamb and her employer paid a premium to defendant CGLIC calculated on either an unfrozen or frozen Social Security integration which was a factor in a computer program "no longer in existence," and the factual assertions made by Secretary Jenson that the employer of plaintiff Lamb had been given a clear choice of premium based on frozen or unfrozen integration. Only discovery by counsel for the plaintiff can resolve the conflicting factual statements made by representatives of defendant CGLIC. Certainly, such apparent conflicting statements should not serve as the basis for a motion for summary judgment.

11. Both the printed and written content of the "Application for Group Insurance" made part of Exhibit "A" attached to the affidavit of Mr. Jenson raises additional fact questions contradictory to the position taken by Mr. Jenson in his affidavit and by counsel for the plaintiff in the "Preliminary Statement" to the Brief In Support of Motion For Summary Judgment that the employer of plaintiff Lamb made a choice between "frozen" and "unfrozen" social security integration with respect to disability income benefits under the standard group long term disability policy at issue.

12. The Application contains several categories of group insurance benefits. Under Item 7 there is printed "Disability Income Insurance." Next to this printed expression there is inked in the words "Long Term." It

is interesting to note that there is no printed choice for frozen or unfrozen social security integration with respect to disability benefits on the Application. Nor did the Overlook Hospital Association representative ink in an indication of a choice of either frozen or unfrozen social integration referred to by Mr. Jenson.

13. An examination of the provisions of the standard Group Long Term Disability Benefits Insurance Policy effective October 1, 1969 of defendant CGLIC attached as Exhibit "A" to the affidavit of Mr. Jenson, reveals a self-evident unconscionable provision under the section "Premiums." The provision under the caption "Amount of Monthly Income in Force" lends substance to the claim of plaintiff Lamb in the verified class action complaint and her affidavit dated January 12, 1978 in support of the Motion To Compel Interrogatories that the premiums paid by her and other persons similarly situated have resulted in the unjust enrichment of defendant CGLIC to the detriment of the beneficiaries of its standard group disability policy and in violation of fiduciary obligations owed plaintiff Lamb and the putative class:

> "For the purpose of determining the premium, the amount of Monthly Income in force under this policy will mean the amount determined in accordance with the Schedule of Benefits *exclusive of any adjustments provided for on account of Other Income Benefits* or any workman's compensation benefit."

Translated into plain words, this clause means that the premiums charged employees under the terms of the policy are calculated *not taking into account* deductions in monthly income benefits categorized under "Other Income Benefits" including "periodic cash payments" provided on account of an employee's disability under the Federal Social Security Act. Thus, by the terms of the group disability insurance contract itself, payment of

premiums are calculated without any allowance for reduction to monthly income benefits while payment of benefits are calculated not only after deduction of the various items enumerated under "Other Income Benefits" but after *taking into account* increases in such "Other Monthly Benefits" when the employee has been declared permanently disabled and thus eligible for disability payments. The interaction of these contract clauses is indeed calculated to reap unconscionable windfall profits for defendant CGLIC which should not be countenanced by this Court under prevailing concepts of federal public policy reflected in Section 207 of the Social Security Act (42 U.S.C., paragraph 407) and the various provisions of the Employee Retirement Income Security Act of 1974 (29 U.S.C.A., paragraph 1001, *et seq.*) and particularly parts four and five of Title I of the latter Act.

14. It is further submitted that the pleadings in this class action pose complex issues of fact and unsettled questions of law involving significant matters of public policy. In the words of an excerpt from the purpose clause of a model regulation to prohibit the offset of increased social security benefits in group disability income policies proposed by the National Association of Insurance Commissions:

> "When Congress increases social security benefits to disabled persons, it is to provide the disabled persons with additional income regardless of any other income or insurance benefits payable to such persons. Accordingly, to permit such an offset would nullify the purpose of the social security legislation and would result in an inequity which is contrary to the expectations of the disabled insured."

In order to fully air the public policy questions at issue in this action there must be adequate opportunity to fully develop the public policy issues relating to the

social security offset practices of defendant CGLIC as well as to obtain necessary discovery.

15. Based on the foregoing, it is respectfully submitted that plaintiff Lamb is not yet in a position to fully present by affidavit facts essential to justify her opposition to the motion for summary judgment. In the exercise of its sound discretion, this Court should deny the motion for summary judgment or, in the alternative, at least order a continuance to permit discovery to be made by counsel for plaintiff Lamb and allow for further development of factual material pertinent to the public policy issues that should be determined in connection with this class action.

Respectfully submitted,

/s/ Robert H. Jaffe
ROBERT H. JAFFE

Sworn and subscribed to before me
this 22nd day of March, 1978.

/s/ Paula K. Daniel
PAULA K. DANIEL
Notary Public of New Jersey
My Commission Expires Dec. 1, 1981
Registered Union County

[SEAL]

EXHIBIT "A"

Attached to Affidavit of Plaintiff

Anneliese B. Lamb

OVERLOOK HOSPITAL
Summit, New Jersey

November 20, 1969

Dear Mrs. Lamb:

Overlook's Long Term Disability Insurance program became effective October 1, 1969. However, since group premium rates are affected by the age, sex and income of its members, final rates could only be determined after the enrollment closed (October 31, 1969). Your adjusted monthly rate is $7.58.

You will note that in most cases this rate is lower than your initial computed rate.

Premium deductions will normally be taken from the first paycheck each month.

In order to bring your monthly payments up-to-date, however, it will be necessary to make the initial deductions in the following manner:

November 20	October premium
December 4	November premium
December 18	December premium

If this should present a particular problem to you, please contact me as soon as possible.

Should you decide to discontinue your Aetna coverage, please sign the enclosed cancellation card and return it to my office.

Very truly yours,

/s/ F. E. Marshall
F. E. MARSHALL
Director of Personnel

EXHIBIT "B"

Attached to Affidavit of Plaintiff

Anneliese B. Lamb

YOUR LOSS

At your present age, if you were disabled, you would have a loss of income to age 65 of $140,558.

MONTHLY CONTRIBUTION

The monthly cost is $1.14 for each $100 of Monthly Benefit. Premiums will be paid by payroll deduction. Your monthly deduction will be $8.34.

Interrogatories Filed September 1, 1977 With Answers Filed December 5, 1977

ROBERT H. JAFFE, P.A.
8 Mountain Avenue
Springfield, New Jersey 07081
(201) 467-2246
Attorneys for Plaintiff

HONORABLE VINCENT P. BIUNNO

Civil Action No. 77-1290

ANNELIESE B. LAMB, individually and on behalf of all other persons similarly situated,
Plaintiff,

v.

CONNECTICUT GENERAL LIFE INSURANCE COMPANY, a corporation of the State of Connecticut,
Defendants.

INTERROGATORIES

TO: McCarter & English
550 Broad Street
Newark, New Jersey 07102
Attorneys for Defendants

PLEASE TAKE NOTICE that the plaintiffs require of the defendant answers to the following Interrogatories within the time prescribed by the Rules of Court.

ROBERT H. JAFFE, P.A.
Attorneys for Plaintiff

By: /s/ Howard G. Schlesinger
HOWARD G. SCHLESINGER

Dated: August 30, 1977

I

Definitions

As used herein:

A. The word "person" means any natural person and any corporation, partnership, association, joint-venture, firm or other business enterprise or legal entity and means both the singular and the plural.

B. The word "document" includes, but is not limited to the original or any copy of books, records, reports, tape recordings or memoranda or notes of conversations and meetings, notes, letters, telegrams, diaries, scheduled graphs, charts, contracts, releases, studies, analyses, cancelled checks, summaries, booklets, circulars, bulletins, instructions, minutes, bills, questionnaires, tapes, tape recordings, correspondence, financial statements and drafts of any of the foregoing, as well as any other tangible things on which information is recorded in writing or sound or in any other manner and including supporting underlying or preparatory material.

C. "Communication" means any oral statement, dialogue, colloquialism, discussion, conversation or agreement.

D. "Identify":

1. When used with reference to a natural person, means to state the full name, present or last known address, past and present positions of any partner, officer of employee of the defendants, and if not such a partner, officer or employee, the occupation or business and position, if known, of such person. When sued with reference to any particular person, the information other than the full name need be given only once.

2. When used with reference to a corporation, partnership, association, firm or other business enterprise or legal entity, means to state the full name and address

and a brief description of the primary business in which such entity is engaged. With respect to any particular entity, the information other than the full name need be given only once.

3. When used with reference to a document, means to state (a) the date, type of document (e.g., letter, memorandum, etc.), author, addressee, recipient, title and file or identifying number; (b) present location and custodian; and (c) the substance thereof *or* to annex to and incorporate in the answers to these interrogatories a true and correct copy thereof. If any such document is no longer under your control, state what disposition was made of it, by whom, and the date thereof.

4. When used with reference to a communication, means to state the substance thereof, the identity of the persons between whom it was made the identity of each person present and the date when it was made, and identify each document in which such communication was recorded or described or referred to.

5. When used with reference to an act, means to state the substance thereof; the identity of the person who participated and/or were present, the date or dates and location thereof, and each document or communication in which such act was recorded or described or referred to.

II

Manner of Answer

In answering each interrogatory:

A. Identify each document or communication or act (1) relied upon in the preparation of each answer, or (2) which forms all or part of the basis for the answer, or (3) which corroborates the answer, or (4) the substance of which forms all or part of the answer.

B. If all the information furnished in answer to all or any part of an interrogatory is not within the personal knowledge of the affiant, identify each person to whom all or any part of the information furnished is a matter of personal knowledge, and each person who communicated to the affiant any part of the information furnished.

C. If the answer to all or any part of the interrogatories is not presently known or available, include a statement to that effect, furnish the information known or available, and respond to the entire interrogatory by supplemental answer in writing and under oath within ten days from the time the entire answer becomes known or available.

1. With regard to the premiums paid by plaintiff Lamb for her group disability policy with Overlook Hospital Association, state how defendant CGLIC arrived at the basis for the initial premium rate of $1.14 for each $100 of Monthly Benefit.

ANS. $1.14 per $100 of Monthly Benefit refers only to the portion of the premium to be paid by the enrolled employee. The total premium of $1.48 per $100 of Monthly Benefit was calculated in accordance with a computer program developed for that purpose which is no longer in existence. The program was based on four factors: 1) frequency of disability occurences based on 1964 Commissioners Disability Table (CDT), 2) terminations rate based on 1964 CDT, 3) loading factors, and 4) Social Security integration calculation based on either unfrozen or frozen Social Security integration.

a. If actuarial calculations and computations were made, state the name and address of each and every person, firm, or organization who prepared these calculations.

ANS. The computer program was prepared by Defendant's Group Actuarial Department.

2. State in detail each and every premium rate increase for the plaintiff Lamb's group disability policy, including the date of each increase and each increased monthly premium rate charged.

ANS. There was one premium increase made for the Overlook Hospital Association policy. Effective September 20, 1971, the total premium was increased from $1.48 per $100 of Monthly Benefit to $2.89 per $100 of Monthly Benefit.

a. If actuarial calculations were made with reference to these increased rates, state the name and address of each and every person, firm or organization who prepared these calculations for the defendants.

ANS. This increase would have been calculated by the Defendant's Group Underwriting department, in accordance with pricing date prepared by Defendant's Group Actuarial department.

3. Did Overlook Hospital Association pay any premium to the defendant for this group disability policy? If so, state:

a. The amount of the premiums paid.

ANS. Overlook Hospital Association was responsible for paying the entire premium of $1.48 per $100 of Monthly Benefit (later $2.89 per $100) to Defendant. It paid the difference between the amount contributed by the employee, which it collected, and the total premium.

b. The actuarial basis for calculating the rate of this premium.

ANS. Same as answer no. 1.

c. If actuarial calculations were made to determine this premium, state the name and address of each

and every person, firm, or organization who prepared these calculations.

ANS. The amount paid by Overlook Hospital Association itself was not based on actuarial calculations, other than those used to determine the total premium.

d. For each and every increase in premium charged, state the amount of premium, the actuarial basis for same, and the name and address of each and every person, firm or organization who prepared the actuarial calculations.

ANS. See answer to Interrogatory No. 2.

e. Whether a trust fund was established for the payment of premiums. If so, designate the name and number of such a fund.

ANS. No.

4. Since October 1, 1969, state the names and addresses of all other organizations, employers and assoications which purchased from defendant CGLIC group insurance policies which included long-term disability programs.

ANS. Object. Interrogatory seeks information which is not relevant to this action and not reasonably calculated to lead to the discovery of admissible evidence. In addition, discovery of the information sought would be unnecessarily burdensome and expensive. In addition, the interrogatory is overly broad in seeking information related to all of defendant's group insurance policies which included long-term disability benefits.

5. For each of the organizations, employers and associations named in #4 above, state:

a. Whether the long-term disability policy purchased was identical in its terms and provisions to the Overlook Hospital Association policy.

ANS. Object. Interrogatory seeks information which is not relevant to this action and not reasonably calculated to lead to the discovery of admissible evidence. In addition, discovery of the information sought would be unnecessarily burdensome and expensive. In addition, the interrogatory is overly broad in seeking information related to all of defendant's group insurance policies which included long-term disability benefits.

b. Whether the long-term disability beneficiary received a "Certificate of Insurance" identical in its terms and provisions to the one given to the employees of Overlook Hospital Association.

6. For each of the policyholders named in answer to Questions 4 and 5, state:

a. The initial premium rates charged to the individual beneficiaries for the long-term disability policy.

ANS. Object. Interrogatory seeks information which is not relevant to this action and not reasonably calculated to lead to the discovery of admissible evidence. In addition, discovery of the information sought would be unnecessarily burdensome and expensive. In addition, the interrogatory is overly broad in seeking information related to all of defendant's group insurance policies which included long-term disability benefits.

b. The date and amount of any and all increases in the premium rates charged.

c. The actuarial basis for calculating both the initial premium rate and any increases.

d. The name and addresses of all persons, firms, or organizations who prepared these actuarial calculations.

7. For each group policyholder, state whether the organization, employer or association paid a premium for their long-term group disability policy. If so, state:

a. The amount of the premiums paid.

ANS. Object. Interrogatory seeks information which is not relevant to this action and not reasonably calculated to lead to the discovery of admissible evidence. In addition, discovery of the information sought would be unnecessarily burdensome and expensive. In addition, the interrogatory is overly broad in seeking information related to all of defendant's group insurance policies which included long-term disability benefits.

b. The actuarial basis for calculating the rate of this premium.

c. The name and address of every person, firm or organization who prepared the actuarial calculations.

8. Prior to entering into the group long-term disability policy with Overlook Hospital Association, effective October 1, 1969, state the names and addresses of all actuaries, attorneys, accountants, economists and other experts utilized by defendant CGLIC to prepare, draft and formulate this group policy.

ANS. The standard policy on which the Overlook Hospital Association policy was based and was developed by Defendant's Group Contract and Group Product Development areas. The individuals involved were Naomi Kahn, Sally Millter and Richard Foote, Connecticut General Life Insurance Company, Hartford, CT 06152. The Defendant's Legal Department and Group Actuarial Department were also involved.

9. Since September, 1972, have there been any revisions, changes or modifications to the group long-term disability policy of Overlook Hospital Association? If so, state the names and addresses of all actuaries, attorneys, account-

ants, economists and other experts utilized by defendant CGLIC to prepare, draft and formulate these revisions, changes or modifications.

ANS. The Overlook Hospital Association long-term disability policy was canceled effective January 9, 1972.

10. Since September, 1972, for each of the group long-term disability policies named in answer 4 and 5, have there been any revisions, changes, or modifications to these policies? If so, for each of the applicable policies, state:

a. The nature of the changes.

ANS. Object. Interrogatory seeks information which is not relevant to this action and not reasonably calculated to lead to the discovery of admissible evidence. In addition, discovery of the information sought would be unnecessarily burdensome and expensive. In addition, the interrogatory is overly broad in seeking information related to all of defendant's group insurance policies which included long-term disability benefits.

b. The effective date of the changes.

c. The reason for the changes.

d. The names and addresses of all actuaries, attorneys, accountants, economists and other experts utilized to prepare the revisions in the policies.

11. Since September, 1972, state the names and addresses of all persons who were at any time and/or at present being paid by defendant CGLIC pursuant to the group long-term disability policy of Overlook Hospital Association.

ANS. The only claim submitted under the Overlook Hospital Association policy was the Plaintiff's claim, insofar as defendant can presently determine.

12. For each person named in answer #11, state:

a. The amount of Monthly Income to which they are entitled.

ANS. Plaintiff is entitled to monthly income benefit of $790.00, reduced by other income benefits as provided in the policy.

b. The amount of any and all reductions for Other Income Benefits.

Plaintiff's monthly income benefit is currently reduced by Social Security Disability Income Benefits of $355.60 per month.

c. The amount of net monthly payment by defendant CGLIC to each disabled beneficiary.

Plaintiff's net monthly payment from defendant is currently $434.40.

13. Since September, 1972, state the names and addresses of all persons who were at any time and/or are at present being paid by defendant CGLIC pursuant to any and all of the group disability policies named in interrogatory answers 4 and 5. Identify the group policyholder for each disabled beneficiary.

ANS. Object. Interrogatory seeks information which is not relevant to this action and not reasonably calculated to lead to the discovery of admissible evidence. In addition, discovery of the information sought would be unnecessarily burdensome and expensive. In addition, the interrogatory is overly broad in seeking information related to all of defendant's group insurance policies which included long-term disability benefits.

14. For each person named in interrogatory answer, 13, state:

a. The amount of monthly income to which they are entitled.

ANS. Object. Interrogatory seeks information which is not relevant to this action and not reasonably calculated to lead to the discovery of admissible evidence. In addition, discovery of the information sought would be unnecessarily burdensome and expensive. In addition, the interrogatory is overly broad in seeking information related to all of defendant's group insurance policies which included long-term disability benefits.

b. The amount of any and all reductions and adjustments to the monthly income entitlement.

c. The amount of net monthly payment by defendant CGLIC to each disabled beneficiary.

15. Since October 1, 1969, have any of the group insurance policies which include long-term disability programs sold and administered by defendant CGLIC named in interrogatory answers 4 and 5 differed from the Overlook Hospital Association policy in their definition of "Other Income Benefits" to include any periodic cash payments provided on account of an employee's disability by the Federal Social Security Act?

a. If so, state the nature of the difference in the policy.

ANS. Object. Interrogatory seeks information which is not relevant to this action and not reasonably calculated to lead to the discovery of admissible evidence. In addition, discovery of the information sought would be unnecessarily burdensome and expensive. In addition, the interrogatory is overly broad in seeking information related to all of defendant's group insurance policies which included long-term disability benefits.

b. For those policies that did not include reductions for Federal Social Security payments, state the names and addresses of all policyholders whose policies at *any* time did provide for reductions for Social Security payments and were subsequently changed.

16. Has the defendant CGLIC ever been sued by any other beneficiary of a long-term disability policy concerning an alleged improper adjustment for Federal Social Security payments?

a. If so, state the name of the case, the docket number, all attorneys involved, and the disposition of same.

ANS. This Interrogatory is objected to on the grounds that it is not relevant to the subject matter of the pending action and not calculated to lead to the discovery of admissible evidence.

17. In the normal course of defendant CGLIC's business, state what communications, including but not limited to correspondence, memoranda, notices, advertisements, and checks, are sent to any and all beneficiaries under any of the group long-term disability policies which you have sold and/or administered.

ANS. This Interrogatory is objected to on the grounds that seeking information relating to the "normal course" of defendant's business is vague and overly broad, not relevant to the facts of the pending action, and not calculated to lead to the discovery of admissible evidence. This Interrogatory is also objectionable on the grounds that in the event the questions are considered to require responses relating to the various practices of defendant in administering its various types of group long-term disability policies, a fully responsive answer would be unnecessarily burdensome and expensive. Without waiving said objections, defendant states that in answer to this interrogatory regular mailings included monthly benefit checks which are sent out by computer, periodic requests for current medical information generally sent every 6 to 12 months or as warranted by the particular case, and notices that benefits will be reduced by upcoming social security increases.

a. For each such communication, state how often same is mailed.

18. In the normal course of defendant CGLIC's business, state what communications, including but not limited to correspondence, memoranda, notices, and advertisements, are sent to any and all policyholders and/or non-disabled potential beneficiaries under any of the group long-term disability policies which defendant CGLIC ha[s] sold and/or administered.

ANS. This Interrogatory is objected to on the grounds that seeking information relating to the "normal course" of defendant's business is vague and overly broad, not relevant to the facts of the pending action, and not calculated to lead to the discovery of admissible evidence. This Interrogatory is also objectionable on the grounds that in the event the questions are considered to require responses relating to the various practices of defendant in administering its various types of group long-term disability policies, a fully responsive answer would be unnecessarily burdensome and expensive. Without waiving said objections and in response to this Interrogatory, defendant states that with respect to non-disabled potential beneficiaries normally the only "communication" would involve distribution of enrollment cards and certificates, which distribution is often handled by the policyholder or its broker and not the defendant.

a. For each such communication, state how often same is mailed.

19. State the names and addresses of all persons who have relevant knowledge of the facts concerning the subject matter of the complaint.

See attached list.

20. State the names and addresses of any and all proposed expert witnesses and annex true copies of all written reports and summaries of all oral reports rendered to you by any such proposed expert witnesses.

ANS. To be supplied.

21. Are there any co-insurers on the group disability policy of Overlook Hospital Association? If so, state the name and address of any and all co-insurers.

ANS. No.

22. Are there any co-insurers on any of the group disability policies named in interrogatory answers 4 and 5? If so, state the names and addresses of any and all co-insurers.

ANS. Yes. Insofar as the interrogatory seeks the names and addresses of any and all co-insurers, it is objected to on the grounds that the information is not relevant to this action and not reasonably calculated to the discovery of admissible evidence. In addition, discovery of the information sought would be unnecessarily burdensome and expensive. In addition, the interrogatory is overly broad in seeking information related to all of defendant's group insurance policies which included long-term disability benefits.

23. With regard to the group disability policy of Overlook Hospital, identify all reports which you filed from October 1, 1969 to the present with all state and/or federal agencies.

ANS. The standard provisions which were used in the Overlook Hospital Association policy were filed with the New Jersey Commissioner of Banking and Insurance in early 1967 and were approved by him in June, 1967.

24. Regarding each and every group disability policy named in interrogatory answers 4 and 5, identify all reports which you filed from October 1, 1969 to the present with all state and/or federal agencies.

ANS. Object. Interrogatory seeks information which is not relevant to this action and not reasonably calculated to lead to the discovery of admissible evidence. In addition, discovery of the information sought would be un-

necessarily burdensome and expensive. In addition, the interrogatory is overly broad in seeking information related to all of defendant's group insurance policies which included long-term disability benefits.

William R. Venberg
Connecticut General Life Insurance Co.
2933 Philadelphia Saving Fund Building
12 South Twelfth Street
Philadelphia, PA 19107

James I. Rose, Jr.
Connecticut General Life Insurance Co.
Hartford, CT 06152

Virginia Covill
Connecticut General Life Insurance Co.
100 North Third Street
Easton, PA 18042

Norma Mendelsohn
Current address unknown.

Jane Eyer
Current address unknown.

Thomas Spina
Connecticut General Life Insurance Co.
51 Commerce Street
Springfield, NJ 07081

Naomi Kahn
Connecticut General Life Insurance Co.
Hartford, CT 06152

Sally Miller
Connecticut General Life Insurance Co.
Hartford, CT 06152

Richard Foote
Connecticut General Life Insurance Co.
Hartford, CT 06152

David Larson
Connecticut General Life Insurance Co.
Hartford, CT 06152

James Grosheider
Connecticut General Life Insurance Co.
Hartford, CT 06152

William McAleney
Current address unknown.

Larry A. Jenson
Connecticut General Life Insurance Co.
Hartford, CT 06152

John F. Randel
Connecticut General Life Insurance Co.
100 N. Third Street
Easton, PA 18042

Evelyn Schabert
Current address unknown.

Martin R. Fishgold
Current address unknown.

F. Chandler Coddington
Spencer M. Madell, Inc.
22 Beechwood Road
Summit, NJ 07901

Michael Payne
Current address unknown.

CANCELLED
AS OF 1-9-72

36703-01-LTD
OVERLOOK HOSPITAL ASSOCIATION

Group Long Term Disability Benefits Insurance Policy

Non-Participating Occupational Contributory

CONNECTICUT GENERAL LIFE
INSURANCE COMPANY

Policyholder: Overlook Hospital Association

Address: Summit, New Jersey

Effective Date: October 1, 1969

Date of Issue: October 30, 1969

Anniversary Date: October 9

Policy Number: 36703-01

The Insurance Company specifies in this policy the terms under which it insures certain Employees and agrees to pay each insured Employee the benefits to which he is entitled in accordance with the provisions contained in the policy.

The policy is issued and accepted subject to all the terms set forth on this page and on the subsequent pages, which are hereby made a part of the policy.

IN WITNESS WHEREOF Connecticut General Life Insurance Company has caused this policy to be executed on the Date of Issue to take effect on the Effective Date.

/s/ W. W. Keffer
Senior Vice President

/s/ [Illegible]
President

/s/ _____
Registrar

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1LT1, 2LT1, 3LT1, 5G1 V-7, 7G1 V-3, 9G1 V-33, 9G2 V-18, 11LT2, 11LT4 V-1, 12LT1 V-7, 21LT1, 30LT1, 34LT1, 34G1, 36G1, 38G1, 40G29, 40LT2

SCHEDULE OF BENEFITS

Employee Classification	Amount of Monthly Income
Each Employee	70% of the Employee's monthly Basic Earnings rounded to the nearest $1.00, but in no event to exceed $1,500.

ADJUSTMENTS IN AMOUNT OF MONTHLY INCOME. The amount of Monthly Income otherwise payable for any monthly period will be reduced by the amount of all Other Income Benefits (as defined in Section 9 of this policy) payable for the same monthly period.

The amount of Monthly Income on each Employee is determined initially by the Employee's monthly Basic Earnings on the day he becomes insured. If the monthly Basic Earnings of any Employee change, any consequent change in the amount of the Employee's Monthly Income will be effective on the October 9 coinciding with or next following the date of change in his earnings, except that no increase in the amount of Monthly Income on an Employee not in Active Service on the day he becomes eligible for the increase will be effective until the day he returns to Active Service. The Insurance Company reserves the right to make any such changes at more frequent intervals.

MINIMUM AMOUNT OF MONTHLY INCOME. The minimum amount of Monthly Income payable for any monthly period of disability of an Employee is $50.00, regardless of any adjustments shown above or in any other section of this policy.

AMOUNT OF INCOME FOR PART OF A MONTH. If benefits are payable for any period of time which is less than a full month, the amount of Monthly Income for such period will be proportionally reduced.

BENEFIT WAITING PERIOD

Employee Classification

Each Employee	180 days

ELIGIBILITY FOR INSURANCE

For Employees

Each Employee in one of the Classes of Eligible Employees shown below will become eligible for Employee insurance on the day he completes the Waiting Period, if any. (The effective date of insurance for an eligible Employee is shown on a subsequent page of this policy.) Any Waiting Period shown below will be waived for an Employee previously insured under this policy whose insurance terminated for a reason other than a) cancellation of his payroll deduction order, or b) failure to return to Active Service immediately following a period of disability for which Monthly Income was or may become payable. However, the Waiting Period will be waived only if the Employee becomes employed in one of the Classes of Eligible Employees shown below within one year after his insurance terminated.

AFFILIATED EMPLOYERS

None

CLASSES OF ELIGIBLE EMPLOYEES

Each Employee who is exempt under the provisions of the Fair Labor Standards Act and who is under 65 years of age

CLASSES OF EMPLOYEES NOT ELIGIBLE

Each Other Employee

WAITING PERIOD

For Employees in the employ of the Employer on the Effective Date of this policy: None

For Employees whose employment with the Employer commences after the Effective Date of this policy: 3 months of continuous Active Service

EFFECTIVE DATE OF INSURANCE

For Employees

Each Employee may elect to be insured for Employee insurance by signing any form of payroll deduction order approved by the Policyholder and acceptable to the Insurance Company. The effective date of his insurance will be:

1. the date on which the Employee becomes eligible, if he signs the payroll deduction order on or prior to that date; or
2. the date on which he signs the payroll deduction order, if that date is within the 30-day period immediately following the date he becomes eligible; or
3. the date on which he is accepted for insurance by the Insurance Company, if he signs the payroll deduction order more than 30 days after the date he becomes eligible or again elects to be insured after his insurance has terminated because of cancellation of the payroll deduction order. To determine his acceptability, the Insurance Company will require evidence of insurability and may require that the evidence be presented by the Employee at his own expense;

provided the Employee is in Active Service on that date; otherwise the effective date of his insurance will be the date he returns to Active Service.

DEFINITIONS

EMPLOYER. The term Employer means the Policyholder and all Affiliated Employers listed in the section entitled "Eligibility for Insurance".

EMPLOYEE. The term Employee means a full-time employee of the Employer, excluding, in any case, part-time employees, temporary employees and employees who work less than 30 hours a week for the Employer.

ACTIVE SERVICE. An Employee will be considered in Active Service with the Employer on a day which is one of the Employer's scheduled work days if he is performing in the customary manner all of the regular duties of his employment with the Employer on a full-time basis on that day either at one of the Employer's business establishments or at some location to which the Employer's business requires him to travel. An Employee will be considered in Active Service on a day which is not one of the Employer's scheduled work days only if he was performing in the customary manner all of the regular duties of his employment on the next preceding scheduled work day.

BASIC EARNINGS. The term Basic Earnings means the Employee's rate of pay, excluding overtime, bonus or additional compensation, based on his normal work week, but in no event for a work week of more than 40 hours. The amount of Basic Earnings which the Policyholder reports to the Insurance Company for any Employee will be considered conclusive on the Employee.

BENEFIT WAITING PERIOD. The Benefit Waiting Period will commence when an Employee becomes disabled and will continue until the end of the period shown in the Schedule of Benefits or until disability ceases, whichever is the earlier.

REHABILITATIVE WORK. The term Rehabilitative Work means work performed under any formal or in-

formal program of rehabilitation approved by the Insurance Company.

RETIREMENT DATE. An Employee's Retirement Date will be (a) the first date as of which he receives retirement benefits under any pension plan with respect to which the Employer contributes or makes payroll deductions or (b) the first date as of which he receives retirement benefits under any state or federal government retirement plan or social security law, other than benefits which become payable solely because of disability or solely because of employment or service with a state or federal government unit, whichever, (a) or (b), is the earlier date.

OTHER INCOME BENEFITS. Other Income Benefits include

(1) any periodic cash payments provided on account of the Employee's disability:

(a) under any group insurance coverage or similar arrangement of coverage for individuals in a group;

(b) by the Federal Social Security Act, including benefits payable to the Employee's dependents on account of the Employee's disability;

(c) by any state or federal government disability or retirement plan;

(d) under any pension plan with respect to which the Employer contributes or makes payroll deductions;

(e) under or on account of any workmen's compensation or similar law;

which become payable on or after the commencement of the disability for which Monthly Income is payable; and

(2) any Federal Old Age Benefits provided under the Federal Social Security Act.

For the purposes of items (1) and (2) above, each Employee who is covered under the Federal Social Security Act will be considered to be receiving periodic cash payments under such Act, in an amount equal to the amount he and his dependents would receive were they receiving such payments, unless the Employee submits proof to the Insurance Company that such payments have been applied for but are not payable.

INSURING PROVISIONS
LONG TERM DISABILITY BENEFITS

Upon receipt by the Insurance Company of due proof that an Employee, while insured under this policy, has become totally disabled, as described below, because of sickness or an accidental bodily injury, the Insurance Company will pay the Employee Monthly Income subject to the following provisions and to all other terms, conditions and limitations of this policy.

If sickness disables an Employee so that he is completely prevented from performing the duties of his occupation or employment and if the disability continues after the Benefit Waiting Period shown in the Schedule of Benefits, the Insurance Company will pay Monthly Income in an amount determined from the Schedule of Benefits. Such Monthly Income will be payable for the period during which the disability from such sickness continues after the Benefit Waiting Period, but for no longer than 24 months. If an Employee, while so disabled, engages in any work for wage or profit (including any Rehabilitative Work), the Monthly Income otherwise payable with respect to any month will be reduced by 70% of the amount of wage or profit to which the Employee is entitled for such work during that month.

If an Employee is so disabled by sickness that he is completely prevented from engaging in any occupation or employment for which he is qualified, or may reasonably become qualified, based on his training, education or experience, and if Monthly Income has been payable for 24 months, the Insurance Company will continue Monthly Income payments during the period he remains so disabled by such sickness.

If an Employee, while so disabled, engages in any Rehabilitative Work, the Monthly Income otherwise payable with respect to any month will be reduced by 70% of the amount of wage or profit to which the Employee is entitled for such work during that month.

If accidental bodily injury, directly and independently of all other causes, disables an Employee so that he is completely prevented from performing the duties of his occupation or employment and if the disability continues after the Benefit Waiting Period shown in the Schedule of Benefits, the Insurance Company will pay Monthly Income in an amount determined from the Schedule of Benefits. Such Monthly Income will be payable for the period during which the disability from such injury continues after the Benefit Waiting Period, but for no longer than 24 months. If an Employee, while so disabled, engages in any work for wage or profit (including any Rehabilitative Work), the Monthly Income otherwise payable with respect to any month will be reduced by 70% of the amount of wage or profit to which the Employee is entitled for such work during that month.

If an Employee is so disabled by accidental bodily injury that he is completely prevented from engaging in any occupation or employment for which he is qualified, or may reasonably become qualified, based on his training, education or experience, and if Monthly Income has been payable for 24 months, the Insurance Company will con-

tinue Monthly Income payments during the period he remains so disabled by such injury.

If an Employee, while so disabled, engages in any Rehabilitative Work, the Monthly Income otherwise payable with respect to any month will be reduced by 70% of the amount of wage or profit to which the Employee is entitled for such work during that month.

If an Employee performs work for which wage or profit is received less frequently than monthly the amount of such wage or profit will be prorated over the number of months during which it was earned. If any payments have been made by the Insurance Company in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of the above provisions, the Insurance Company will have the right to recover these payments, to the extent of the excess.

In any case, Monthly Income payments for any period of disability caused by sickness will automatically cease on (1) the first date as of which the Employee receives retirement benefits under any pension plan with respect to which the Employer contributes or makes payroll deductions or (2) the later of (a) the Employee's 65th birthday or (b) the date as of which the 12th Monthly Income payment for that disability is payable, whichever, (1) or (2), is the earlier date.

SUCCESSIVE DISABILITIES. Successive disabilities resulting from the same or related causes will be considered one disability unless the disabilities are separated by the Employee's return to Active Service for at least 3 consecutive months.

Successive disabilities resulting from unrelated causes will be considered a continuation of the first disability unless separated by the Employee's return to Active Service for at least one full day.

CERTAIN DISABILITIES CONSIDERED TO RESULT FROM SICKNESS. A period of disability will be considered to result from sickness if it (a) results directly or indirectly from sickness or infection, or medical or surgical treatment therefor (except pyogenic infections which occur through an accidental cut or wound), or (b) is caused or contributed to by hernia of any kind or injuries resulting in hernia of any kind.

If a period of disability due to accident commences more than 90 days after the date of the accident, that period of disability will be considered to result from sickness.

LIMITATIONS

The insurance under this policy does not cover, and no benefits will be paid for, disability caused or contributed to by

1. pregnancy, childbirth or miscarriage;
2. intentionally self-inflicted injuries, while sane or insane;
3. war, declared or undeclared, or any act or hazard of war;
4. a bodily injury or sickness for which the Employee, during the 6-month period prior to the date his insurance under this policy becomes effective, incurred expenses, received medical treatment, took prescribed drugs or medicines or consulted a physician, unless the disability commences after the 12-month period immediately following the date the Employee's insurance under this policy becomes effective;

nor for any period of disability

5. during which the Employee is not under the care of a legally qualified physician; or

6. caused or contributed to by mental illness or functional nervous disorder after Monthly Income has been payable for 24 months for that disability, except while the Employee is continuously confined in a legally constituted hospital for 14 days or more and during the 3-month period immediately following any such confinement.

TERMINATION OF INSURANCE

The insurance on any Employee will automatically terminate on the earliest of the following dates:

1. the date the Employee ceases to be in a Class of Eligible Employees or ceases to qualify as an Employee;
2. the last day of the period for which the Employee has made the required contribution, if any, toward the cost of the insurance;
3. the date this policy is discontinued;
4. the Employee's Retirement Date;
5. the Employee's 65th birthday;
6. the date of termination of employment. Termination of Active Service will be considered termination of employment, and the insurance will be discontinued, except as provided below.

   If an Employee's Active Service terminates because of injury or sickness for which Monthly Income is or may become payable under this policy, the insurance will continue during the Benefit Waiting Period and during the period for which Monthly Income is payable. If the Employee remains disabled for a period of time longer than the period for which Monthly Income is payable, the insurance will terminate at the end of the period for which Monthly Income is payable. The Employee's insurance will be reinstated

immediately upon payment of premiums for that Employee by the Policyholder if the Employee returns to Active Service in a Class of Eligible Employees as soon as he ceases to be disabled.

WAIVER OF PREMIUM

If an Employee's Active Service terminates because of injury or sickness for which Monthly Income is payable under this policy, premium for that Employee will be waived during the period Monthly Income is payable.

EXTENSION OF LONG TERM DISABILITY BENEFITS

If disability for which Monthly Income is payable commences while this policy is in force, Monthly Income will be payable after termination of the policy to the same extent as if the policy had not terminated.

TABLE OF MONTHLY PREMIUM RATES

Classification of Employee	Monthly Premium Rate Per $100.00 of Monthly Income
Each Employee	$1.48

PREMIUMS

METHOD OF PREMIUM PAYMENT. Premiums will be payable monthly unless the Policyholder and the Insurance Company agree on some other method of premium payment. The Policyholder and the Insurance Company may agree to change the method of premium payment from time to time.

PREMIUM DUE DATE. The Premium Due Date will be the day of the month which corresponds numerically with the Anniversary Date or the last day of a month in which there is no day which corresponds numerically with the Anniversary Date. If the Policyholder and the

Insurance Company agree to the payment of premiums on a quarterly, semiannual or annual basis instead of on a monthly basis, the Premium Due Date will occur at the appropriate regular interval, quarterly, semiannually or annually.

PAYMENT OF PREMIUMS. The initial premium will be due on the Effective Date to cover the period from that date to the first Premium Due Date which is one month or more after the Effective Date. Premiums thereafter will be due on each succeeding Premium Due Date. Premiums are payable at the Home Office of the Insurance Company or to an authorized agent of the Insurance Company.

CALCULATION OF PREMIUMS. If premiums are payable monthly, the premium as of any Premium Due Date will be calculated by multiplying the Monthly Income in force on each Employee on that date by the premium rate for that Employee and adding the results. If premiums are payable other than monthly, the calculation is the same except that the monthly rate for each classification is first converted into a quarterly, semiannual or annual rate by multiplying it by 2.9852, 5.9557 or 11.8227 respectively, the result being taken to the nearest cent. If the Policyholder and the Insurance Company agree to a change in the method of premium payment or to a change in the Anniversary Date, an appropriate pro rata adjustment will be made in the premium due.

AMOUNT OF MONTHLY INCOME IN FORCE. For the purpose of determining the premium, the amount of Monthly Income in force under this policy will mean the amount determined in accordance with the Schedule of Benefits exclusive of any adjustments provided for on account of Other Income Benefits or any workmen's compensation benefit.

MONTHLY STATEMENT DATE. If premiums are payable monthly, the Monthly Statement Date will be

the same as the Premium Due Date. If premiums are payable quarterly, semiannually or annually, the Monthly Statement Date will be the day in each month which corresponds numerically with the Premium Due Date or the last day of any month in which there is no day which corresponds numerically with the Premium Due Date.

MONTHLY PREMIUM STATEMENTS. If premiums are payable monthly, a Monthly Premium Statement will be prepared as of the Premium Due Date reflecting the premium payable. If premiums are payable quarterly, semiannually or annually, a Monthly Premium Statement will be prepared as of the Monthly Statement Date covering the period from the Monthly Statement Date to the next Premium Due Date. This Monthly Statement will reflect any pro rata premium charges and credits due to changes in the number of Employees insured and changes in the amount of insurance for individual Employees which took place during the preceding month.

SIMPLIFIED ACCOUNTING. For an Employee becoming insured or for an increase in the amount of insurance on any Employee, other than an increase resulting from a change in the Schedule in Benefits, the premium charge will commence on the Monthly Statement Date coinciding with or next following the date the insurance or the increase in insurance is effective. Similarly, for an Employee whose insurance terminates the premium charge will cease on the Monthly Statement Date coinciding with or next following the date of termination of the insurance, and for a decrease in the amount of insurance on any Employee, other than a decrease resulting from a change in the Schedule of Benefits, the premium charge will be decreased on the Monthly Statement Date coinciding with or next following the decrease in the amount of insurance.

ADJUSTMENTS IN PREMIUM RATES. The premium rates shown in the Table of Monthly Premium Rates

may be changed by the Insurance Company from time to time upon at least 31 days advance written notice, but no change will be made during the first 12 months following the Effective Date, nor will any increase be made more often than once during any 12-month period. If an increase in premium rates takes place on a date other than a Premium Due Date, there will be due on the date the increase takes place a pro rata premium for the period from the date of the increase to the next Premium Due Date. If the pro rata premium is not paid when due, this policy will automatically be discontinued as of the date the pro rata premium was due, subject to the provisions entitled "Grace Period", and the Insurance Company will refund the portion of the premium which is unearned on the day this policy is discontinued. If a decrease in premium rates takes place on a date other than a Premium Due Date, a pro rata credit will be granted for the period from the date of the decrease to the next Premium Due Date.

As of any Anniversary Date after this Policy has been in force for twelve months, the Insurance Company may grant a credit in such amount as it may determine, based upon experience. The experience under this policy may be combined with the experience under other group insurance policies issued by the Insurance Company to the Policyholder.

DISCONTINUANCE OF THE POLICY

The Policyholder may discontinue this policy as of any Premium Due Date by giving the Insurance Company written notice in advance of that date.

The Insurance Company may discontinue this policy as of any Premium Due Date if the total number of insured Employees is less than 25 or less than 75% of the total number eligible.

If any premium is not paid when due, this policy will automatically be discontinued as of the Premium Due Date, except as provided below.

GRACE PERIOD. If, prior to any day on which premium is due, the Policyholder has not given written notice to the Insurance Company that this policy is to be discontinued, a grace period of 31 days will be granted for the payment of every premium after the initial premium, during which time this policy will be continued in force. If any premium is not paid before the expiration of the grace period, this policy will automatically be discontinued at the expiration of the grace period, except that if the Policyholder has given written notice in advance of an earlier date of discontinuance, this policy will be discontinued as of the earlier date. The Policyholder will be liable to the Insurance Company for any unpaid premium for the time this policy was in force.

MISCELLANEOUS PROVISIONS

EXECUTION OF POLICY. This policy is executed at the Home Office of the Insurance Company, the Post Office address of which is Hartford, Connecticut.

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of the premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms and conditions of this policy pertinent to the benefit.

WORKMEN'S COMPENSATION. This policy is not to be construed as satisfying any requirement for coverage by workmen's compensation insurance.

INSURANCE DATA. The Policyholder will furnish the Insurance Company with all the data necessary for the calculation of the premium and all other data that may

reasonably be required by the Insurance Company. Failure on the part of the Policyholder to furnish the necessary data will neither invalidate any Employee's insurance nor continue any Employee's insurance beyond the date of termination determined in accordance with the section entitled "Termination of Insurance".

PROVISIONS

ENTIRE CONTRACT; CHANGES. This policy and the application of the Policyholder, a copy of which is attached to this policy, and the applications, if any, of the Employees will constitute the entire contract between the parties. All statements made by the Policyholder or by an insured Employee will be considered representations and not warranties, and no statement made for the purpose of obtaining insurance under this policy will be used in any contest to avoid the insurance or reduce the benefits provided by this policy unless contained in a written application for the insurance.

No change in this policy will be valid unless approved by the Insurance Company and evidenced by endorsement on this policy or by amendment to this policy signed by the Policyholder and by the Insurance Company, acting through its President, Vice President, Secretary or Assistant Secretary. No agent has authority to change this policy or to waive any of its provisions. The validity of any change in this policy will not be affected by the failure to obtain the consent of any Employee.

NOTICE OF CLAIM. Written notice of claim must be given to the Insurance Company within 30 days after the occurrence of the event on which claim is based.

Written notice of claim given by or on behalf of the Employee to the Insurance Company at its Home Office, or to any authorized agent of the Insurance Company,

with particulars sufficient to identify the Employee, will be considered notice to the Insurance Company. Failure to give written notice within the time provided in this policy will neither invalidate nor reduce any claim if it be shown that it was not reasonably possible to give written notice within that time and that written notice was given as soon as was reasonably possible.

CLAIM FORMS. The Insurance Company, when it receives the notice of claim, will furnish to the Employee or to the Policyholder for delivery to the Employee, the claim forms which it usually furnishes for filing proofs of loss. If the Employee does not receive these claim forms within 15 days after receipt by the Insurance Company of the notice of claim, the Employee will be considered to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in this policy for filing proofs of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

PROOFS OF LOSS. Written proof of loss must be furnished to the Insurance Company at its Home Office within 90 days after the date of the loss for which claim is made. Failure to furnish written proof of loss within the time provided in this policy will neither invalidate nor reduce any claim if it be shown that it was not reasonably possible to furnish written proof of loss within that time and that written proof of loss was furnished as soon as was reasonably possible.

PHYSICAL EXAMINATION. The Insurance Company, at its own expense, will have the right and opportunity, while claim is pending under this policy, to examine any individual whose injury or sickness is the basis of claim when and so often as it may reasonably require and to make an autopsy in case of death where it is not prohibited by law.

TIME OF PAYMENT OF BENEFITS. Upon receipt of due proof, disability income benefits will be paid by the Insurance Company at regular intervals occurring at least as often as once a month, and any balance remaining unpaid at the end of any period for which the Insurance Company is liable will be paid at that time.

PAYMENT OF BENEFITS. All benefits will be payable to the Employee.

FACILITY OF PAYMENT OF BENEFITS. If an Employee is a minor or, in the opinion of the Insurance Company, otherwise not competent to give a valid receipt for payment of any benefit due him under this policy and if no request for payment has been received by the Insurance Company from a duly appointed guardian or other legally appointed representative of the Employee, the Insurance Company may, at its option, make direct payment to the individual or institution appearing to the Insurance Company to have assumed the custody or the principal support of the Employee.

If an Employee dies while disability income benefits remain unpaid, the Insurance Company may, at its option, make direct payment to any of the following surviving relatives of the Employee: wife, husband, mother, father, child or children, brothers or sisters; or the executors or administrators of the Employee.

Any payment by the Insurance Company in accordance with this Facility of Payment of Benefits provision will discharge the Insurance Company from all further liability to the extent of the payment made.

LEGAL ACTIONS. No action at law or in equity will be brought to recover on this policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of this policy, nor will any action be brought at all unless brought within 3 years from the expiration of the time within which proof of loss is required by this policy.

TIME LIMITATIONS. If any time limitation provided in this policy for giving notice of claims, for furnishing proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the state in which the Employee resides at the time this policy is issued, then the time limitation provided in this policy is hereby extended to agree with the minimum permitted by the law of that state.

PHYSICIAN-PATIENT RELATIONSHIP. The Employee will have free choice of any doctor practicing legally. The Insurance Company will in no way disturb the physician-patient relationship.

NEW EMPLOYEES. New Employees will become eligible for benefits under this policy in accordance with the provisions set forth in the section entitled "Eligibility for Insurance".

CERTIFICATES. The Insurance Company will issue to the Policyholder, for delivery to each insured Employee, an individual certificate which will summarize the essential features of the insurance coverage to which the insured Employee is entitled, including the provisions, if any, limiting the coverage or reducing the benefits on account of age, and will state to whom the benefits provided by this policy are payable. Nothing in the certificate will be construed to change, modify or invalidate any of the terms and conditions of this policy.

CONNECTICUT GENERAL LIFE
INSURANCE COMPANY

Hartford, Connecticut

APPLICATION FOR GROUP INSURANCE

1. Name of Applicant

   Overlook Hospital Assoc.

2. Main address

   193 Morris Ave., Summit, N.J. 07901

3. Nature of business

   Hospital

4. Classes and locations of individuals eligible

   Exempt Salaried Employees

5. Subsidiary and affiliated companies included

   None

6. Total number of individuals eligible

   93

   For individual benefits

   93

   For dependent benefits

   Have any of the classes of individuals eligible been covered under a group insurance policy or any other form of group plan within the past five years? Yes

If so, please specify the benefits, the underwriting company or organization, and the dates these benefits were terminated Life, Major Medical, Provident Life & Acc.—Tenn.—In Effect. Group Blue Cross-Blue Shield

7. GROUP INSURANCE APPLIED FOR (please check)

Individual	Dependent	
☐	☐	Life Insurance
☐	☐	Accidental Death and Dismemberment Insurance
☒	—	Long Term Disability Income Insurance
☐	☐	Hospital Expense Benefits
☐	☐	Surgical Expense Benefits
☐	☐	Doctor's Attendance Benefits
☐	☐	X-Ray and Laboratory Expense Benefits
☐	☐	Medical Catastrophe Expense Benefits
☐	☐	Comprehensive Medical Expense Benefits
☐	☐	_____
☐	☐	_____

8. EFFECTIVE DATE REQUESTED: 10/1/69 Group Insurance at the Insurance Company's rates and under the terms and conditions of the policy or policies applied for will take effect as of the Effective Date Requested provided that this Application is accepted at the Home Office of the Insurance Company and provided that if certain individuals eligible are to contribute to the cost of any of the Group Insurance, such Group Insurance will become effective on the date the required number have enrolled or on the Effective Date Requested, whichever is the later date. If this Application is not accepted, no insurance will become effective and any premium payment advanced by the Ap-

plicant will be refunded upon surrender of the Conditional Receipt.

9. THE APPLICANT DECLARES that he has read the statements and the answers to the above questions and that to the best of his knowledge and belief they are complete and true. The Applicant understands and agrees that this Application is offered as an inducement for the issuance of the insurance applied for, that it will form a part of any policy issued, that no information given to, or acquired by, any representative of the Insurance Company will bind the Insurance Company unless it appears in writing on this Application and that no waiver or modification will bind the Insurance Company unless in writing and signed by an Executive Officer of the Insurance Company. The Applicant further understands that no coverage will be provided for any individual unless the individual is eligible under the terms of the policy or policies issued.

Dated at Summit, New Jersey on September 30, 1969

Name of Applicant Overlook Hospital Assoc.

By: Edward A. Dougharty, Associate Director

Witness: /s/ [Illegible]

Soliciting Agent if other than Witness: /s/ [Illegible]

Statement to be signed by both parties on payment of the premium or any part thereof.

I HEREBY DECLARE that I have paid to ———— Agent Five Hundred Dollars for which I hold his receipt.

Date 9/30/69

Applicant: /s/ Edward A. Dougharty, Assoc. Dir.

No. 53308

AMENDMENT TO APPLICATION

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

Hartford, Connecticut

It is hereby requested that the Application For Group Insurance, No. 53308, dated September 30, 1969, be amended so that

1) With respect to Name of Applicant, Box 1 is changed to read as follows:

Overlook Hospital Association

This amendment shall be attached to and form a part of the above application.

Dated at _____
(*City and State*)

OVERLOOK HOSPITAL ASSOCIATION
(*Name of Applicant*)

On _____

Witness _____

By _____

APPENDIX E

RELEVANT STATUTORY PROVISIONS AND REGULATIONS

Section 202(d)1, Social Security Act, 42 U.S.C. § 402(d)1:

(d) Child's insurance benefits. (1) Every child (as defined in section 416(e) of this title) of an individual entitled to old-age or disability insurance benefits, or of an individual who dies a fully or currently insured individual, if such child—

(A) has filed application for child's insurance benefits,

(B) at the time such application was filed was unmarried and (i) either had not attained the age of 18 or was a full-time student and had not attained the age of 22, or (ii) is under a disability (as defined in section 432(d) of this title) which began before he attained the age of 22, and

(C) was dependent upon such individual—

(i) if such individual is living, at the time such application was filed,

(ii) if such individual has died, at the time of such death, or

(iii) if such individual had a period of disability which continued until he became entitled to old-age or disability insurance benefits, or (if he died) until the month of his death, at the beginning of such period of disability or at the time he became entitled to such benefits,

shall be entitled to a child's insurance benefit for each month, beginning with the first month after August 1950

in which such child becomes so entitled to such insurance benefits and ending with the month preceeding whichever of the following first occurs—

(D) the month in which such child dies or marries,

(E) the month in which such child attains the age of 18, but only if he (i) is not under a disability (as so defined) at the time he attains such age, and (ii) is not a full-time student during any part of such month,

(F) if such child was not under a disability (as so defined) at the time he attained the age of 18, the earlier of—

(i) the first month during no part of which he is a full-time student, or

(ii) the month in which he attains the age of 22,

but only if he was not under a disability (as so defined) in such earlier month, or

(G) if such child was under a disability (as so defined) at the time he attained the age of 18, or if he was not under a disability (as so defined) at such time but was under a disability (as so defined) at or prior to the time he attained (or would attain) the age of 22, or, subject to section 423(e) of this title, the termination month (and for purposes of this subparagraph, the termination month for any individual shall be the third month following the month in which his disability ceases; except that, in the case of an individual who has a period of trial work which ends as determined by application of section 422(c)(4)(A) of this title, the termination month shall be

the earlier of (I) the third month following the earliest month after the end of such period of trial work with respect to which such individual is determined to no longer be suffering from a disabling physical or mental impairment, or (II) the third month following the earliest month in which such individual engages or is determined able to engage in substantial gainful activity, but in no event earlier than the first month occurring after the 15 months following such period of trial work in which he engages or is determined able to engage in substantial gainful activity, or (if later) the earlier of—

(III) the the first month during no part of which he is a full-time student, or

(IV) the month in which he attains the age of 22,

but only if he was not under a disability (as so defined) in such earlier month.

Section 207, Social Security Act, 42 U.S.C. § 407:

§ 407. Assignment

The right of any person to any future payment under this subchapter shall not be transferable or assignable, at law or in equity, and none of the moneys paid or payable or rights existing under this subchapter shall be subject to execution, levy, attachment, garnishment, or other legal process, or to the operation of any bankruptcy or insolvency law.

20 C.F.R. § 404.970 Transfer of assignment:

The Administration shall not certify, as provided in § 404.968, any amount for payment to an assignee or transferee of the person entitled to such payment under the act, nor shall the Administration certify such amount for payment to any person claiming such payment by

virtue of an execution, levy, attachment, garnishment, or other legal process or by virtue of any bankruptcy or insolvency proceeding against or affecting the person entitled to the payment under the act.

20 C.F.R. § 404.1601 Payments on behalf of an individual:

When it appears to the Administration that the interest of a beneficiary entitled to a payment under title II of the Act would be served thereby, certification of payment may be made by the Administration, regardless of the legal competency or incompetency of the beneficiary entitled thereto, either for direct payment to such beneficiary, or for his use and benefit to a relative or some other persons as the "representative payee" of the beneficiary. When it appears that an individual who is receiving benefit payments may be incapable of managing such payments in his own interest, the Administration shall, if such individual is age 18 or over and has not been adjudged legally incompetent, continue payments to such individual pending a determination as to his capacity to manage benefit payments and the selection of a representative payee.

20 C.F.R. § 404.1603 Responsibility of representative payee:

A relative or other person to whom certification of payment is made on behalf of a beneficiary as representative payee shall, subject to review by the Administration and to such requirements as it may from time to time prescribe, apply the payments certified to him on behalf of a beneficiary only for the use and benefit of such beneficiary in the manner and for the purposes determined by him to be in the beneficiary's best interest.

20 C.F.R. § 404.1605 Conservation and investment of payments:

Payments certified to a relative or other person on behalf of a beneficiary which are not needed for the current

maintenance of the beneficiary except as they may be used pursuant to § 404.1607, shall be conserved or invested on the beneficiary's behalf. Preferred investments are U.S. Savings Bonds, but such funds may also be invested in accordance with the rules applicable to investment of trust estates by trustees. For example, surplus funds may be deposited in an interest or dividend-bearing account in a bank or trust company, in a savings and loan association, or in a credit union, if the account is either federally insured or is otherwise insured in accordance with State law requirements. Surplus funds deposited in an interest or dividend-bearing account in a bank or trust company, in a savings and loan association, or in a credit union, must be in a form of account which clearly shows that the representative payee has only a fiduciary, and not a personal interest in the funds. The preferred forms of such accounts are as follows: ..... (Name of beneficiary) by ..... (Name of representative payee) representative payee; or ..... (Name of beneficiary) by ..... (Name of representative payee) trustee.

U.S. Savings Bonds purchased with surplus funds by a representative payee for a minor should be registered as follows: ..... (Name of beneficiary) ..... (Social Security No.), a minor, for whom ..... (Name of payee) is representative payee for social security benefits.

* * *

A representative payee who is the legally appointed guardian or fiduciary of the beneficiary may also register U.S. Savings Bonds purchased with funds from title II payments in accordance with applicable regulations of the U.S. Treasury Department (31 C.F.R. 315.5 through 315.8). Any other approved investment of the beneficiary's funds made by the representative payee must clearly show that the payee holds the property in trust for the beneficiary.

20 C.F.R. § 404.1607 Support of legally dependent spouse, child, or parent:

If current maintenance needs of a beneficiary are being reasonably met, a relative or other person to whom payments are certified as representative payee on behalf of the beneficiary may use part of the payments so certified for the support of the legally dependent spouse, a legally dependent child, or a legally dependent parent of the beneficiary.